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ABSTRACT

A conference held in 1987 at Dartmouth explored the design and implementation of a comprehensive, coordinated community-wide approach to promoting the health of families and children. This publication provides: (1) conference presentations; (2) reports of delegations from Maine, Vermont, and New Hampshire; (3) participants' discussion of issues; and (4) related materials. Presentations concerned: (1) a rationale for a community-wide approach to promote the health and development of families and children; (2) a community-based approach to preventing heart disease; (3) a way of empowering at-risk families through community-based family support programs; (4) social marketing; (5) community-wide approaches to preventing preterm birth; (6) community-wide approaches to promoting the health and development of families with children; and (7) a school system-based approach to promoting healthy families and children. A summary of the information presented at the conference attempts to answer questions concerning the need for a community-wide approach, basic design elements, implementation of programs, program evaluation, and progress at the state level in the reporting states. Also included are a summary of program status indicators, a framework for promoting healthy families and children, a risk factor checklist, and summaries of individual and environmental factors affecting health. (RH)

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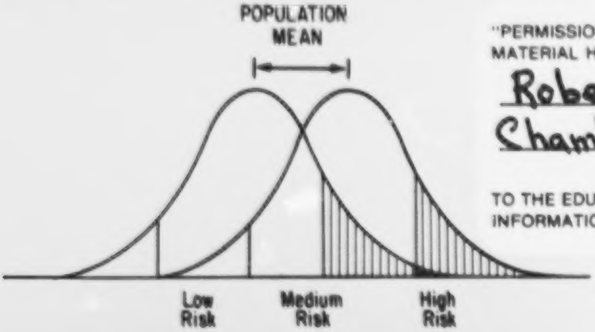
BEYOND INDIVIDUAL RISK ASSESSMENT: COMMUNITY WIDE APPROACHES TO PROMOTING THE HEALTH AND DEVELOPMENT OF FAMILIES AND CHILDREN



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Conference Proceedings

Edited by:
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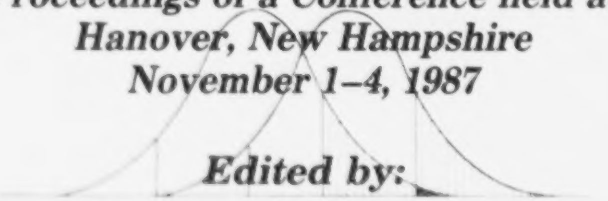
Proceedings of a Conference held at
Hanover, New Hampshire
November 1–4, 1987



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Acknowledgement

This conference and publication was the end result of contributions from many people. For many of the overall concepts associated with an ecologic approach, I am indebted to Urie Bronfenbrenner of Cornell University and a number of his former graduate students, particularly David Olds and Heather Weiss.

In terms of how to implement these concepts, my horizons were expanded from a rather narrow "Magic Bullet" approach with home visiting to a more comprehensive and coordinated community wide orientation through contacts with a number of people in this country and abroad. Professor Fredric Brimblecombe from Exeter, England jolted my complacency by writing the following comments in the published proceedings of a conference on home visiting that I helped organize in 1980: "I do not believe that one can take out 'home visiting' and look at it in isolation . . . Yes, home visiting is one of its very important instruments, but to evaluate it in isolation from so many other significant influences is in my judgment not possible . . . take a full orchestra playing a symphony, who has the arrogance to say which of the instruments is unnecessary or which is the most important." This statement troubled me, as I was a strong advocate for home visiting, but I didn't really understand the significance of it until I heard Dr. Farquhar talk about the Stanford programs. I then realized what it meant to implement a comprehensive, coordinated, non-deficit oriented, community wide approach to health promotion. Further help was given by the World Health Organization which provided me with the opportunity to visit three Scandinavian countries and see first hand how such principles could be applied to a whole country. Other assistance was provided me by Dr. Gene Schwartz, epidemiologist, who called my attention to the two articles by Dr. Geoffrey Rose from England that showed me how to integrate the concept of risk into an ecologic framework.

The encouragement of Woodie Kessel and George Little was particularly helpful during the initial planning period and when I was looking for the necessary funding. I am particularly indebted to Michael Galan, Chief of the Bureau of Special Medical Services, who gave me much in kind support from a budget that was already stretched to the limit and encouragement to work on the primary prevention of developmental problems in a setting oriented primarily to treatment.

Sally Trachear, Nancy Peacock, and especially my wife, Sylvia, were particularly helpful in working out the logistics before, during, and after the conference.

For manuscript preparation I am extremely indebted to the careful and competent work of Denise Musumeci who could always be counted on to come through in a pinch.

CONFERENCE PARTICIPANTS

1. Christine Jackson Ph.D

Dr. Jackson is Associate Director of Education, Stanford Center for Research in Disease Prevention, Stanford University. She is responsible for designing and implementing risk reduction programs in communities and for conducting the large scale evaluations necessary to determine the extent to which risk reduction programs are maintained by the community and the association between participation in risk reduction programs and improvement in risk related behaviors.

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2. Katherine Kamiya Rubino

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3. Richard Manoff

Mr. Manoff founded Richard K. Manoff, Inc. in 1956 which became one of the leading marketing and advertising firms in the United States. He became interested in applying marketing techniques to public health problems following participation in a U.S.A.I.D. mission on nutrition in India in 1967. Shortly thereafter, he founded Manoff International, Inc. and has helped carry out public health projects in Ecuador, the Philippines, Nicaragua and other Third World nations. He has served as Adjunct Lecturer in Public Health at Columbia University School of Medicine, and is author of: *Social Marketing: New Imperative for Public Health* (Praeger, 1985).

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4. Emile Papiernik, M.D.

Dr. Papiernik is a professor at the Universite Paris-Sud and Chief of Service in Obstetrics and Gynecology of Hopital Antoine Beclere in Clamart, France. Dr. Papiernik has conducted a number of studies on community wide approaches to preventing pre-term birth in several areas of France and in Martinique. He helped establish a national pre-term birth prevention program throughout France based on his work. A book summarizing these studies will be published by the March of Dimes some time in 1988 to 1989.

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5. Edward Zigler, Ph.D.

Dr. Zigler is Sterling Professor of Psychology at Yale University, Head of Psychology at Yale's Child Study Center, and Director of the Bush Center in Child Development and Social Policy. Dr. Zigler was a member of the National Planning Committee of Project Head Start and Follow Through and was the first director of the U.S. Office of Child Development and Chief of the Children's Bureau from 1970 to 1972. He is editor and author of numerous books and publications including *Children, Family, and Government*, Cambridge University Press, 1983, which is particularly relevant to this conference.

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6. Donald Pierson, Ph.D.

Dr. Pierson is professor of Education and director for Field Services and Studies of the Department of Education at Lowell University in Massachusetts. He was director of the Brookline Early Education Program and a consultant to the state wide parent education and support program implemented through the public school system in Minnesota. A book by Dr. Pierson entitled *Early Education in the Public Schools* will be published by Jossey-Bass in 1989.

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7. Heather Weiss, Ed.D.

Dr. Weiss is Director and Principal Investigator of the Harvard Family Research Project of the Harvard Graduate School of Education. She was former Director of The Yale Family Support Project which identified and disseminated information on innovative family support programs in a publication entitled: *Programs to Strengthen Families*. Dr. Weiss is currently studying state initiatives for providing education and support to families.

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8. Robert W. Chamberlin, M.D., M.P.H.

Dr. Chamberlin is the conference organizer and editor of the proceedings. He is an Associate Professor of Maternal Child Health at the Dartmouth/Hitchcock Medical Center and Medical Director of the Child Development Program of the Bureau of Special Medical Services of the New Hampshire State Division of Public Health. He recently completed an eight week WHO Fellowship to study how health care, child care, and social services are organized and coordinated for families with young children in 3 Scandinavian countries and Great Britain.

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2. Woodie Kessel, M.D., M.P.H., Acting Director, Division of Maternal and Child Health, Program Coordination and System Development, U.S. Public Health Service, Rockville, MD
3. Susan Bunting, Executive Director, Foundation for Seacoast Health, Portsmouth, NH
4. Kathleen Sgambati, Director, Planning and Review, Division of Public Health, Concord, NH 03301.

SOME MEMORABLE CONFERENCE QUOTES

Jackson:

. . . "When viewed from this (ecological) orientation, a health promotion program is an attempt to influence individual behavior through changes in the surrounding physical and social environment." . . .

. . . "When considered as a whole *the model depicts the* comprehensive *nature of the intervention. It is comprehensive because it targets multiple risk factors with programs and products that involve multiple community settings, change strategies and target groups." . . .*

. . . "Our goal in putting the (advisory) board together was to pull together the decision makers or power brokers in the community" . . .
. . . "One of the first lessons I had to learn in my role was that I couldn't come to the board and define a problem. I think its very important to let them define the problem and get a sense of ownership about the problem. Our general approach is to present them with needs assessment information and see whether they think it's a problem. I think this is a really important aspect of collaboration with the board." . . .

. . . "The point is that we don't take an idea and develop it in isolation within the university. Throughout the process our work is guided *by the information we collect from individuals and organizations in the community." . . .*

. . . "What is the smallest unit of intervention within which the comprehensive approach is possible?" . . . . . . "I think it's what is the largest unit in which you can expect to have a sense of community, and what does that mean. It means a shared purpose, and it means an ability to coordinate program efforts to pull off this kind of comprehensive results." . . .

. . . "I think a basic decision your group needs to make is whether you want to change the way you currently do program work. Most of this is geared toward improving the way we do existing programs vs. really stepping back and saying: Do we need to completely reorganize them, build a framework and then drop the programs within that, and then look at the picture?". . . . . . "It's a very different approach than saying we've got programs and we've learned some things here that we can apply to our programs". . . . . . . "I think there's a need for a higher order, a bigger picture." . . .

Rubino:

. . . "The Ounce develops non-deficit strategies which enable families to help themselves and to encourage their neighbors and communities to adopt and support this type of structured self-help programming." . . .

. . . "We have mobilized young people, we've mobilized the adults that are significant in their lives, we've changed the way organizations that serve young people in that community operate, and we've created some new opportunities for change in the system that I think is different." . . .

. . . "We are beginning to have state agency directors talking about the fact that they do not do enough on the helping continuum at the prevention end and that they need to devote more of their resources to preventive services. That is something that was rarely heard, even two or three years ago." . . .

. . . "While there are still challenges in terms of joint planning, we have a model and a super structure so that the people from youth employment for instance are actually talking to the people in education about the fact that they're serving a lot of the same kids. It seems remarkable that this never happened before or that it did not happen as effectively as it's happening now." . . .

. . . "We believe that our work and partnership with community organizations and with the focus on prevention is the clear direction for public policy and services for young children and families." . . .

Manoff:

. . . "Social marketing is like marketing itself, a demand strategy, a strategy for creating effective demand for service." . . .

. . . "Communications development had become a two-way process: To communicate with the people in order to ascertain how to communicate to them. *It established the pre-eminence of 'feed forward', over 'feedback' — to listen and learn from the people in advance so that program design might benefit from that input." . . .*

. . . "I'm not just putting emphasis on this kind of research because I think it's proper, I don't move without doing it. I have learned a tremendous amount from people to who eventually we want to address messages." . . .

. . . "You need to identify your target audiences and see what segmentation may exist there. You check out your concepts with them by conducting a searching inquiry to discover things you need to know for effective message design such as resistances that have to overcome. The secret of effective message design is dealing with those barriers. Simple problem solution messages are only restatements of your objectives and your goals but they're not messages designed to move people to a desire for the behavior change that you are seeking to promote." . . .

. . . "What I want to emphasize most is this business of doing your upfront inquiries. I have the impression that the amount of this that you do is practically negligible and you're surprised to discover how little sex appeal "parenting" has to your target audience." . . .

Papiernik:

. . . "In your country preterm deliveries are considered a minority problem. It's not true. This is one of the reasons that Northern New England didn't get the grant. You were not bad enough. You were not minority enough. But you had a rate of 7% for preterm deliveries and 6% for low-birth weight and if you compare these to the rates of Sweden and Norway which are 4%, then you are very bad." . . .

. . . "In the Haguenau Study, we look at the health related behavior of specific risk groups and this is one of the outcomes of our study that is very important. Specific risk groups, behaved exactly as the general population. They didn't accept being labelled at risk. This means to us you cannot modify the behavior of the women at risk if you don't modify the behavior of the total population of pregnant women. This is one of the major results of our study." . . .

. . . "Home visits are very important for the psychological support and conveying of information. For this we have done a controlled trial showing that for the very low educated women, who are at high risk for social reasons, this is one o the best ways to spread the information. This is because they don't read the pamphlets and don't understand the radio and TV ads. They have to have a personal relationship with a knowing woman, taking one hour at a time to look on all the details and this is very important." . . .

. . . "How does prevention work. It works by reducing the rates of risk factors in the general population. The number of women with a

previous preterm birth was reduced in the population as a result of our policy, so that for the next pregnancy she was less at risk." . . .

Zigler:

. . . *"My own feeling is that the magnitude of the long-term effects of Head Start really depends upon two factors: How involved Head Start parents become in the optimum socialization and education of their own children, and, the extent to which schools follow the Head Start program with further intervention efforts."* . . .

. . . *"We've learned a great deal over the past 22 years at Head Start. We also are now aware of some of the errors we made early on. One error was searching for some magic period during which fairly minimal intervention would have major effects in changing the course of the child's development."* . . . . . . *"The fact is that there is no single magic period in the process of development for the simple reason that each and every period is a magical and important one."* . . . . . . *"I am convinced that for each period of development there are environmental nutrients which stimulate further development and/or buffer the child against stress and adverse events experienced during that period. And, of course, the Head Start program provides just such environmental nutrients."* . . .

. . . *"What we should be working on is not increasing IQ scores but rather the production of socially competent human beings who use all the intelligence they possess."* . . .

. . . *"It may be in all the errors we made, the one that I haven't even mentioned that always has bothered me is putting all poor children in one set of centers and all more wealthy children somewhere else. Now in fairness to the founders of Head Start, of which I was only one, we put into place a principle that 10% of the children could be non-poverty children. Well, that was way too small and I had to do it all over again, that would have to be at least 1/3 to get any of the benefits that I think that that kind of intermixing could give children."* . . .

. . . *"The child care system that worries me the most in the United States is the family day care system. It's very heterogeneous. You find everything in it, from the excellent to the awful."* . . . . . . *"Too many parents think that when they buy child care, they're buying the service that allows them to go to work. We have to transmit that they are buying an environment which determines in considerable part the* *growth and development of their children. If that growth and development is going to be optimal, we have to have built into it the closest kinds of partnership between the caretakers and the parents."* . . .

. . . *"I am something of a historian and I suggest that you go back and read the first Social Security law in this country. It is pathetic. It's a guaranteed recipe for poverty, for old people, but what happens is you get a principle into place, then you build on it, and over time Social Security in this country, while still not great, is quite defensible. I'm working very hard for the Child Care Bill not because I think it's a great Bill but because I like the principle. If I can get that principle into place then over time we can work on it and make it better. If we lose it, we don't pass it, then there's nothing to make better."* . . .

Pierson:

. . . *"To avoid the potential stigma and deficit orientation of serving only at risk children, we decided the program should be open to all families; but strategies should be developed to attract families who are unlikely to hear about or volunteer for such an innovative program* . . .

. . . *"The home visits and parent groups focused on understanding normal child development, on developing networks of people who cared about and assisted each other, and on developing a sense of community, a sense of belongingness into the town."*

. . . *"Perhaps, the main insight gained from this survey was that no component is crucial for all families. Rather, the reassurance, the validation for the role of the parent is the essence of any component, and different parents found this in different ways."* . . .

. . . *"A second theme that was gained in a variety of ways was the understanding and appreciation of their child as a unique and important individual, to gain some understanding of the rate of development, the wide range of normal development, and that no child is perfect. A third theme was the friendships that were developed. Many of the parents told us that even at the end of 2nd grade several of their closest friendships were those they had formed early-on. Parents whose children are now in 8th or 9th grade still tell me they maintain those friendships, even with some who have moved away from Brookline. It is surprising how many of those friendships formed early in the child's life were so important to them."*

. . . "When we considered the results for children whose parents were less highly educated, this revealed an especially significant finding for policymakers: an early education program with minimal parent education services (no home visits) shows no school performance benefits for these children. Families with great needs require more than the availability of a drop-in center, even if an early childhood program and health and developmental monitoring are offered." . . .

BEYOND INDIVIDUAL RISK ASSESSMENT:

COMMUNITY WIDE APPROACHES TO PROMOTING THE HEALTH AND DEVELOPMENT OF FAMILIES AND CHILDREN

Preface to the Conference

For the purposes of this conference we are defining a community wide approach as one that incorporates at least the following basic components:

(1) A defined geographic area with its permanent residents;

(2) Some kind of coordinating council to identify needs, set priorities for program development, coordinate activities, and monitor the effects over time;

(3) An array of accessible and affordable programs to promote the health and development of the family;

(4) A social marketing component to educate the community and its leaders and service providers about the need for primary prevention programs to strengthen families and what each family can do for itself to develop a more healthy life style.

(5) Sustained long term funding through legislation.

As discussed by Rose in two recent articles (1985,87) community wide approaches to health promotion should be considered when risk factors for negative outcomes are wide spread throughout the community and risk scores follow the pattern of the familiar bell shaped distribution curve with the bulk of the population falling in the intermediate risk range and much smaller numbers of persons with high and low scores making up the tails of the distribution. If risk scores are at least somewhat linearly related to negative outcomes, concentrating resources only on those at highest risk will have little impact on the incidence of related conditions for the population as a whole. This is because the basic underlying conditions that caused this distribution is the first place are not being changed and in the long run more "cases" will come from the much larger population at "medium" risk than the much smaller population at "high" risk. Also, longitudinal studies have shown that for many problems of maternal child health, an individuals risk status is in constant fluctuation as life circumstances change so that a measure of status at any one point in time is not a very accurate predictor of future problems. (Chamberlin, 1984) In addition, experience tells us that it it more difficult to change the behavior or status of a high risk person than preventing one at medium risk from reaching that position in the first place. For example, it is usually a lot harder for the chain smoker and the alcoholic to reduce their consumption than it is for the person who is smoking a half pack of cigarettes a day or having a daily cocktail. Finally, it is harder for anyone to give up an undesirable health related habit such as eating a high cholesterol diet when everyone else is doing it and to change makes one stand out from ones peers.

For all these reasons, the preferred preventive strategy for many problems is to try and change the average risk scores of the population as a whole. This is because a small shift of the mean will have a large effect on reducing the number of individuals that end up in the high risk end of the distribution. In a normal distribution (bell shaped curve) half of those in the top ten percent will move to below that level if the mean falls by as little as a third of a standard deviation. Furthermore such a strategy will have a long term if not permanent effect in reducing the number of persons reaching high risk status. If non smoking, regular exercise, and eating low cholesterol foods becomes normal it becomes easier and easier to persuade people to adopt these behaviors because every one is doing it. In addition these behavioral changes are reinforced by community wide changes such as the types of food being stocked by supermarkets and the setting up of no smoking areas in restaurants and offices.

Problems With Community Wide Approaches: Rose goes on, however, to point out some of the disadvantages of a community wide or population strategy. It's hard to sell to the public and politicians. For example it offers only a small benefit to each individual since many of them would not have developed the problem even without some specific intervention. Most unimmunized persons will not get Diptheria, most people not wearing seat belts will not get killed in a car accident, and most egg and sausage eaters will not die from cardio-vascular disease. Because of this there is often poor motivation on the part of the individual to change his or her behavior. Similarly, trying to get practitioners to carry out prevention programs is often difficult because "grateful patients are few in preventive medicine where success is marked by a non event." In addition the skills needed to change health habits are unfamiliar and professional esteem is lowered by a lack of success. "Harder to overcome than any of these, however, is the enormous difficulty in getting medical personnel to see health as a population issue and not merely as a problem for individuals." (Rose, 1985)

One can add that politicians have the same trouble and often find it more politically expedient to focus attention on the tip of the iceberg rather than on its underlying mass. This can be done by either blaming the victim for their own misfortune or targeting a small amount of resources to help those in the most trouble with the hope of getting "the biggest bang for the buck." For example recent reactions to the increasing problem of homeless families include passing it off as a problem of drunks and the mentally ill or paying for temporary shelters without dealing with the underlying problems of lack of affordable housing, educational opportunities, affordable quality child care programs, and job training. It is easier to sell legislators on appropriating a small amount of money for an obvious problem that needs immediate attention than a larger amount of money for a program whose effects may not be visible for several years.

Another draw back, as we will see in this conference, is that population strategies are complicated to carry out. To do this successfully takes experience in using the mass media, inter organizational collaboration at the state and local level, and the participation of non governmental organizations such as churches and business groups. There must also be a willingness to divert some treatment monies into revenues to fund the necessary primary prevention services. Because of this complexity it is rare to see significant reductions in problem incidence in less than three to five years.

Finally, in a population approach, a small benefit to the individual can easily be outweighed by a small risk. Rose provides the example of a large clinical trial using the drug clofibrate to lower serum cholesterol. When all the data was analyzed, the drug seemed to have killed more people than it saved even though the fatal complication rate was only about 1 per 1000 persons per year. Such low order risks are difficult to detect unless careful epidemiologic monitoring of large populations is carried out over considerable periods of time.

In summary an approach that concentrates on treating persons only after they reach a "high risk" status may be necessary in the short run for communities where it will take time to to get a preventive program in place or as one part of a more comprehensive approach, but if relied on completely for problems resulting from conditions that are widespread in the community it will have little long term impact.

As will be documented in a later presentation, epidemiologic studies have shown that many of the major problems in maternal child health in terms of their frequency of occurrence and/or their cost for care such as low weight births, deaths and hospitalizations of children under one, injuries, child abuse and neglect, and lack of school readiness are related to the mothers health habits before, during and between pregnancies and her parenting skills after the child is born. These habits and skills are in turn related to how well a parent is coping with his or her balance between the life stresses encountered and the emotional and instrumental support he or she is receiving from the surrounding environment. (Chamberlin and Keller, 1982)

Risk factors that have been identified as contributing to parental dysfunction include stresses such as having insufficient income to cover basic living expenses, poor housing, living in unsafe neighborhoods, being discriminated against, frequent moves, relationship problems, having large numbers of closely spaced children, having an atypical child who is difficult to care for, having problems accessing high quality affordable child care, getting time off from work for child birth and for the care of sick children, and having a lack of knowledge about and experience in child rearing. In addition being a single parent without a supportive spouse or companion, living away from grandparents and other support persons, and/or living in an isolated rural setting or area with little sense of community often leads to problems in coping because of feelings of loneliness and depression, and sometimes substance abuse.

These risk factors are now widespread throughout our communities because of high divorce rates, an increasing number of out of wedlock and teenage births, and a shifting economy resulting in job instability, loss of benefits, fewer high paying manufacturing jobs, and more low paying service jobs. In addition increasing costs of housing, transportation, education, and health care, a large increase in the numbers of mothers working outside the home, an increase in families headed by inexperienced teenagers, and cut backs in government funding for housing, transportation, and social programs, have increased family stress loads considerably. Finally, there has been a loss in community cohesiveness because of urban sprawl, geographic mobility, and less family involvement with religious and other community support groups. (National Academy of Sciences, 1976; Kenniston, 1977; Kammerman and Hayes, 1982; Hobbes et al, 1984; Orr, S. and James, S., 1984; Sidel, 1986; Monihan, 1986; Edelman, 1987; Kagan et al, 1987).

Currently our resources are directed largely at rescuing children after some disaster has occurred such as being born of low birth weight, being abused or neglected, becoming a delinquent, or failing in school. Preventive programs that are funded are largely targeted to various high risk individuals or families rather than to the community as a whole. We need then to consider a population or community wide strategy to deal with these problems and the purpose of this conference is to learn from the experience of others how this might be done.

The presentations at the conference were tape recorded and a typed transcript prepared. This in turn has been edited to improve clarity and occasionally new information has been added to touch on a point not adequately covered in the discussion. Some after thoughts and additional material are provided at the end of the presentations and discussion.

Robert W. Chamberlin, M.D., M.P.H.
Conference Coordinator and Editor
Hanover, N.H. November 1, 1987

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Conference on Community Wide Approaches to Promoting the Health & Development of Families and Children

November 2-4, 1987
Held at Hanover, New Hampshire

Welcome by Dr. George Little

I thought it important to explain the role of the Department of Maternal Child Health here at Dartmouth and the reasons why we're co-sponsors. We're the only Department of Maternal and Child Health in an academic medical center and a medical school in the country. We are truly an integration of obstetrics and pediatrics. We include genetic services and adolescent medicine. We're relatively small. We have a group of 8 or 9 obstetricians and gynecologists with 3 subspecialties represented. About 4 or 5 years ago, we added a very active group of nurse midwives. That group of nurse midwives is now responsible for almost half of our normal spontaneous vaginal deliveries. It's been a very exciting part of the program to add the nurse midwives into our OB-GYN section and into our teaching program for medical students. Our pediatric section includes 15 or 16 pediatricians representing general academic pediatrics and most of the subspecialties. One of the things that we've tried to do very hard is to integrate our program as closely as possible with the activities of the State of New Hampshire. We're a private medical center, one of the smallest if not the smallest in the country, and we happen to be eccentric in the state, up in the central part of Vermont and New Hampshire on the border. The state capitol is over in Concord and, as most of you know, much of the population of the State of New Hampshire is in the lower Merrimack River valley and down along the border with Massachusetts so that we've got challenges that occur with that. As the medical center has grown in the last 10 years or so, one of the initiatives of the Department of Maternal and Child Health has been to try to stay as close as possible and, in fact, to play a leadership role within the activities in the state.

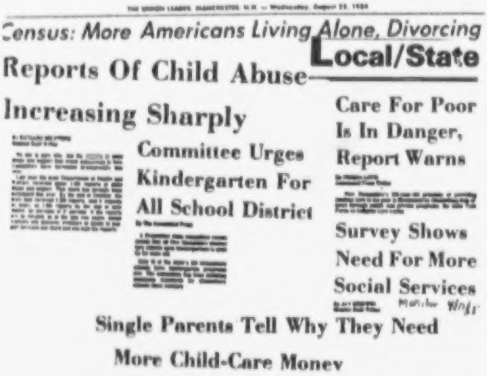
When the situation arose where it was possible to have Bob Chamberlin not only come to the state and be a faculty member in our department, but to actually live and work over in the State capital which is in Concord about 60 miles from here, I saw that as a tremendous opportunity. I think that we see it coming to fruition in meetings of this type where he provides leadership and integration between the activities that are occurring under the egress of the State of New Hampshire and other private foundations and institutions around the country and the medical center up here in this corner of the state. So I really see this meeting as kind of a symbol of what I hope we'll see more of in the future and a continuation of this kind of activity where we attempt to integrate our resources and activities in order to meet certain goals and objectives related to Maternal and Child Health.

My clinical activities have been in establishing a tertiary level intensive care nursery in the State of New Hampshire and getting that program off the ground and going. The fact remains, however, the more I do of that, the more I recognize that what's going on in discussions such as what's happening here over the next 2 or 3 days is where the action has to be, and regardless how many babies we deal with and how well we treat respiratory distress syndrome or prematurity, it just has been and remains very, very clear to me that there are real difficiencies in certain areas and we're not addressing them entirely or adequately. For me, as a person focusing in on perinatal care and reproductive medicine, the big things in my mind right now tend to be preconceptual care; in other words, getting people into the proper mind frame to have children if you will and all the things that are associated with that and in the follow-up care. When I look at the babies coming through the Intensive Care Nursery, I just see tremendous needs in terms of how much of that might have been prevented with what I'll label preconceptual care. We can argue about that as we go through the next couple of days: The needs on that side of the equation and the needs on the other side of the equation as we send children out in the community and see how disorganized and fragmented and unknowing at times care happens to be. It's going to be a busy couple of days. I look forward to learning a tremendous amount and, hopefully, when things break up on Wednesday morning, we'll have some kind of document or statement or some thoughts down on paper. In the meantime, welcome to Hanover and the community. I look forward to working with you and I'll turn the podium over to my friend and associate here, Dr. Chamberlin.

Rationale For a Community Wide Approach to Promote The Health and Development of Families and Children

Presented by Robert W. Chamberlin, M.D., M.P.H.

Thank you Dr. Little. First, let me present my idea about why we're here. I'm a developmental pediatrician and I go around the state and see children under six who have developmental problems. We perform a multidiscipline assessment and then try and find services for the children and/or their families. I work in clinics from the southern part of the state in Nashua up to Berlin in the north, and what I'm seeing are large numbers of highly stressed families. This causes me considerable concern. I see families who have $10,000 medical bills because they didn't have medical insurance when their child got sick. I've just seen my first couple with a $10,000 educational bill because both had to borrow to finish college. I see families working double shifts where the mother is working during the day and the father is working during the night because they can't afford day care. I see a lot of isolated, lonely, and depressed mothers living out in trailers in rural areas, and I see young, inexperienced parents trying to raise children without the assistance of grandparents who were available to help out in the past. These are not isolated incidents. In the three years that I've been in New Hampshire, I've collected headlines that I see in the local papers which give you another view of what is happening to families in New Hampshire.



Census: More Americans Living Alone, Divorcing

Local/State

Reports Of Child Abuse Increasing Sharply

Committee Urges Kindergarten For All School District

Care For Poor Is In Danger, Report Warns

Survey Shows Need For More Social Services

Single Parents Tell Why They Need More Child-Care Money

Again I think the message is that there are a lot of highly stressed families trying to survive in the cities and out in the rural areas. But I'm concerned not only from a humanitarian standpoint but also because it has a major impact on all of our State agencies. I see each of our agencies spending large amounts of money trying to treat some narrow aspect of the fallout from family dysfunction and almost nothing to prevent them from floundering in the first place. One of the more useful ways I've found to think about this, is to picture what's happening along the banks of a river.

Downstream at the bottom the picture are all the state agencies. They're throwing life preservers to kids who are drowning; this includes case work and foster care for kids who have been abused and neglected, neonatal intensive care for low-birth weight and sick babies, emergency room and hospital care paid for by medicaid, for kids who are injured and have illnesses like diarrhea and pneumonia, special education services for kids who are failing in school, and jail and rehabilitation programs for youths who are having trouble because of delinquency and/or substance abuse. This is where millions of dollars are being spent in our state agencies now. We're just beginning to move up to the next level, the secondary prevention level. Here we are trying to recognize the problems earlier and provide early intervention programs to prevent children from needing more expensive care later on. That is what I am doing in my job as a developmental pediatrician. Around our state I see very little being done upstream in the primary prevention area. This is where all the children are getting thrown in the river by the types of family dysfunction that I've described. The question, then, is how can we begin to shift some of our resources up into that area to prevent all these children from developing these problems in the first place. Since one of the basic assumptions underlying this model and the need for a community wide approach to prevention is that these kinds of health and developmental problems of children and youth are related to family dysfunction, I first want to document this fact with the following review of the literature:

A number of studies of pregnancy outcome and of the determinants of the health and development status of the young child have demonstrated significant relationships between these and the health habits of the mother before, during, and between pregnancies and her parenting skills after the child is born. These habits and skills have in turn been related to how much stress she has encountered in her current and past living situation, how well she is coping with these past and present stresses, and how much emotional and instrumental support she is receiving from family, friends, and human service organizations.

Pregnancy Outcome: The mother's health habits before, during, and between pregnancies have all been related to birth rates for low weight babies: These include pre-pregnant weight and nutritional status, age at conception, use of prenatal care, weight gain during pregnancy, use of alcohol and cigarettes, exposure to other environmental toxins, physical exertion, and birth interval. (Miller and Merritt, 1979; Brent and Harris, 1976; Metcoff et al 1981; Papiernik, 1984; Lieberman et al, 1987).

Environmental stress such as having low income, poor housing, being single, having less help during pregnancy, experiencing more life changes, and not having a support person present during labor and deliver have also been related to utilization of prenatal care and pregnancy outcome. (Hetzel et al, 1961; Birch and Gussow, 1970; Nuckolls et al, 1972; Sosa et al, 1982; Norbeck and Tilden, 1983; Ramsey et al, 1986; Lieberman et al, 1987; Pascoe et al, 1987). Although the effects of the later on specific health habits have not been well established except on utilization of prenatal care, outreach programs supplying education, and emotional support to expectant mothers have been able to modify smoking and eating behavior, and patterns of physical exertion enough to improve the birth weight of the child (Paige, D. et al, 1981; Olds et al, 1986; Papiernik, 1985).

Health Status of The Young Child: Hospitalizations, Injuries, Abuse and Neglect. In the classic study of "A Thousand Families in Newcastle Upon Tyne" in which all the children in the city born during a two month period were followed into adolescence, a strong relationship was found between early ratings of the mother's parenting skills and a number of health outcomes including injuries and whether or not the child was hospitalized during the first year of life: (Spence et al, 1954)

"In the study of the families and in attempting to correlate their environments with the health of the children, there emerged one dominating factor: the capacity of the mother. If she failed, her children suffered. If she coped with life skillfully and pluckily, she was a safeguard of their health." (pp 120)

"An infant whose mother was unable to cope was twice as liable to be admitted (to the hospital) as a child from a family where the mother was able to exercise satisfactory care" (pp 157)

In a more recent study of another large cohort of British children followed from birth to age five (Butler and Golding, 1986) it was found that differences in hospital admission rates were more strongly related to the family living situation than social class. "Children whose natural mothers were either single and unsupported or living with a step father were 50% more likely to have been admitted at all and nearly twice as likely to have had multiple admissions when compared with children having both natural parents." (pp 247)

In a study from New Zealand (Beautrais et al, 1982) in which over a thousand children were followed from birth to age four, family life event scores based on the occurrence and frequency of such events as moves, job changes and unemployment, marital relationship problems, illnesses in family members, pregnancy, and legal problems were associated with increased risk of medical consultation and hospital attendance for illness of the lower respiratory tract, gastroenteritis, accidents, and ingestions of toxic materials. In addition, children from families experiencing large numbers of life events had an increased risk of hospital admissions for suspect or inadequate care. Multivariate analysis showed that the apparent correlations between life events and child health remained virtually unchanged when the data were controlled for the effects of a number of familial and social status indicators such as maternal age, ethnicity, educational level, family size, and standard of living:

"For individual measures of morbidity, the associations between life events scores and risks of morbidity are not large, but when the data were aggregated over a range of conditions that were sensitive to family life event variations, large differences emerged. Children whose mothers had experienced 12 or more life events during the three year period had rates of hospital admissions for one or more of the above conditions that were six times higher than those children whose mothers had experienced three or fewer life events and rates of total medical attendance that were more than twice as high . . . This implies that future research in this area should perhaps concentrate more on the effects of life events on child health and well being in general and less on the effects of life events on the risks of specific types of morbidity."

In a study of injuries in a large national cohort study in England it was found that frequency of occurrence in families was related to a number of factors including having two or more children, living in poor neighborhoods, frequent moves, and having a teenage mother. Children of teen mothers were also more likely to be admitted to the hospital for an episode of gastro-enteritis (Taylor et al, 1983).

In a study of over 400 births which occurred in 3 inner city census tracts in Detroit Smiley et al, (1972) found that the mother's reports of illness in her infant during the first three months of life were more likely to come from families in which the mother was trying to cope with a recent move, had less help with housework and child care, and reported more feelings of nervousness, tension, and/or depression.

In a study of a large sample of one year olds (N = 4,986) from eight different areas in the United States, McCormick et al (1980) found that rates of hospitalization increased among families where the mother was non-white, young, and/or the sole adult in the home. Also in another report on this sample, McCromick et al, (1981), injuries (both hospitalized and non-hospitalized) were more likely to have occurred in infants of young and/or single unemployed mothers. These relationships were modest, but held up when controlled for mother's education, income, and other social status indicators.

Holter and Friedman (1968) found a number of obviously unsafe environments when they made visits to the homes of children under six seen in the emergency room because of injuries. Many of the families were coping with high stress loads and appeared socially isolated. After careful investigation it was found that about 10% of the children had actually been physically abused.

Glass et al (1971) found that rehospitalization of infants discharged from an intensive care unit was related to socioenvironmental factors. They constructed a risk scale composed of four items: failure of the mother to receive prenatal care = 2, absence of father from the home = 1, receipt of public assistance

= 1, other children in the home = 1. Rates of rehospitalization were more than 3 times greater for infants with family scores of 4 or more than for those with 2 or less. Hack et al (1981) also found that rehospitalization for very low birth weight infants was a continuum of perinatal and environmental morbidity.

In a follow up study of 255 low birth weight babies discharged from an intensive care unit, Hunter et al (1978) found that the ten families who were subsequently reported for the abuse and/or neglect of their child during the first year of life had described themselves as more socially isolated and as having more financial problems than others during the initial interview at the time the child was admitted to the intensive care nursery.

In a pilot study in one California county it was found that supplying a home visitor to families with a recent graduate from a neonatal intensive care unit reduced the incidence of rehospitalization and abuse and neglect of low birth weight babies. Although never published, the report convinced the legislature to fund these services on a permanent basis in this area. However, no additional money has been provided to expand the program into other areas (Centerwall, 1984).

Other studies of abused and neglected children find relationships with increased family stress loads and decreased social support from family and friends. (Belsky, 1980) In the classic study of child neglect among low income families by Giovanni and Billingsley, (1970), it was found that neglectful mothers were more likely to have more children, have experienced a recent marital disruption and be without a husband, to be poorer, to be without material resources for caring for their children, and to be more socially isolated from relatives. There were no significant difference in the mother's own experience in being reared. Both neglecting and non-neglecting mothers often had a history of deprivation in their own upbringing. This led the authors to conclude: "It is the current situational strains that predominate among neglectful parents, not those of their past life."

In a matched case control study, Justice and Duncan (1976) report a higher incidence of life changes in families reported for abusing and/or neglecting a child. In a case control study of pediatric social illness (accidents, ingestions, failure to thrive, child abuse), children under age four admitted to Boston Children's Hospital or seen in the emergency room with one of these diagnoses were contrasted with a control group of children admitted or seen with other non-chronic conditions. When compared to the control groups, the families of these children reported receiving less regular health care, more recent moves, more child rearing problems, a history of a broken home in the mother's childhood, and a period of mother initiated separation from the child. (Morse, et al, 1977)

Looking at the problem of child abuse from a community wide focus Garbarino (1976, 1978, 1980) noted that neighborhoods with high abuse rates had fewer people free from drain available to form natural helping networks. High risk neighborhoods were those with large numbers of persons preoccupied with meeting their own pressing needs such as single parent families, working mothers with dependent children, and transients. Neighborhoods with high abuse rates also had a higher incidence of mothers receiving inadequate prenatal care, and higher rates of low birth weight and infant mortality. Steinberg et al (1981) found increasing rates of child abuse in two large metropolitan communities as unemployment rates increased. Others have noted an association between child abuse and low birth weight. (Goldson et al, 1976; Klein et al 1971)

Crockenberg (1987) found that adolescent parents with poor support systems were more likely to respond angrily and punatively in their attempts to control the behavior of their toddler. Olds et al, (1986) found that supplying a home visitor to young, single, low income mothers reduced the incidence of abuse and neglect and improved parenting skills.

Developmental Status of the Child: Previous studies have shown a significant relationship between the stimulation and support aspects of the child rearing environment and the child's scores on standard speech, language, and intelligence tests, measures of social competence, and functioning in school (White & Watts, 1973; Cohen & Beckwith, 1979; Bradley and Caldwell, 1976, 1980; Elardo, Bradley, and Caldwell, 1977; Werner, Bierman, and French, 1971). For example, in the longitudinal study reported in the last reference all the children born on one of the Hawaiian Islands over a two year period were followed into their teen age years. By age ten 39% were having some difficulty in school. "The educational stimulation received in the home as evaluated when the child was age two was the best criterion to differentiate between children with and without achievement problems, IQ's below 85, language and preceptual problems." "Of the children whose homes were rated high in educational stimulation only 9 (14%) had achievement problems in school. In contrast 276 (62%) of the children in whose homes few or more of these opportunities were available had difficulties with the basic skill subjects in school" (Werner et al, 1971).

A similar finding was reported in the collaborative perinatal study in the United States in which 28,000 children were evaluated periodically from birth to age 7. For those considered as low achievers in school at age seven it was found: "For low achievers as a whole, these findings suggest that although they differed in several areas of development from their academically successful IQ matched controls, the largest and most consistent differences in etiologic significance were in aspects of the family environment closely associated with opportunities for verbal conceptual stimulation." (Broman,1984)

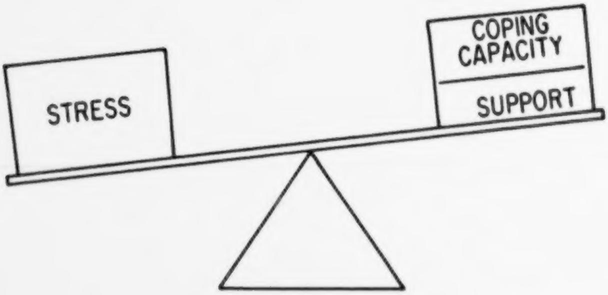
Other studies indicate that the ability of the mother to provide this kind of development promoting environment is in turn related to her ability to cope with the balance between stress and support that she is receiving in her current living situation. For instance in divorced families, the availability of support from friends, neighbors, and kin was positively related to the mothers effectiveness in interacting with her preschool child (Hetherington, Cox and Cox, 1976). In another study by Pascoe, Loda, et al (1981, 1984) it was found that a measure of mother's social support was related to her scores on the Caldwell Inventory of Home Stimulation. This is a measure of parenting skill that has been related positively to a variety of child development outcomes. Crnic, Greenberg, et al (1983) demonstrated significant relationships between measures of stress and support, and maternal attitudes and child rearing behavior with four month old babies. Crockenberg (1981) found that social support helped mothers cope with irritable infants and resulted in a more secure pattern of infant-mother attachment at one year of age.

As was found in the New Zealand studies, it is often the accumulation of stresses that appears to tip the balance toward a negative outcome. In a longitudinal study reported by Sameroff et al (1987): "Verbal IQ scores of a socially heterogeneous sample of 215 four year old children were highly related to a cumulative environmental risk index composed of maternal (education, mental health, knowledge and attitudes about child development, observed parenting behavior), family (size, presence or absence of the father, stressful life events) and cultural (minority group status, socio-economic status) variables." Like the study of child neglect by Giovanni and Billingsley, they found that while being of low income increased the likelihood of a poor outcome for any child, it was the accumulation of stresses within an income group whether it be low or high that tipped over the balance for a particular family. "The multiple pressures of environmental context in terms of amount of stress from the environment, the family's resources for coping with that stress, the number of children that must share those resources, and the parent's flexibility in understanding and dealing with their children all play a role in fostering or hindering child intellectual and social competence."

However, other recent studies looking at children who have developed well in spite of poverty environments and in some cases mentally ill mothers have added an "invulnerability" dimension in the child as a contributing factor. (Werner and Smith, 1982) Children who did well in poor environments were noted to be more active and socially responsive as infants and more able to attract the positive attention of others than children experiencing similar adverse environments who did not do well. However, as a group, those children who did well encountered less other stress in their life situation and had more support in the way of other family and friends which helped them cope with their mentally ill parents. So it appears it is the fit between the coping capacity and assets of the mother and/or child with the stresses and supports encountered in the environment that determines the developmental outcome.

The concept of goodness of fit between a child or parent and his or her environment as a determinant of developmental outcome is also noted by Chess and Thomas (1984) in their longitudinal studies of the behavioral and emotional development of children with different behavioral styles and levels of central nervous system dysfunction. Fergusson et al (1984) found that mothers who responded to increasing life events with symptoms of depression also reported more problems with the behavior of their five year old children. Belsky (1984) summarizes this data in a model relating the psychological resources of the parent, contextual stress and support, and characteristics of the child with developmental outcome. It is this mix of interrelated variables that makes it so difficult to predict who will need what kind of services at some point in the future.

THE FAMILY BALANCING ACT



In summary, these studies indicate that a wide variety of health and developmental problems of children are related to parenting dysfunction and this is in turn related to how well the parent or parents are coping with their current balance of stress and support. One of the major tasks then for a community that wishes to promote the health and development of its children is to examine what it can do to help parents and children to cope. As discussed in the preface, strategies for doing this have generally fallen into two groups. Some advocate for targeting resources only to people identified as being at "high risk" for a particular problem such as producing a low weight baby, others argue for a community wide approach to modify the underlying conditions related to all the problems mentioned. As Giovanni and Billingsley state in their study of child neglect among the poor: "Planning, obtaining, and integrating the services and resources needed by the women in this study go beyond the individual protective service worker and beyond the agency itself. These are community problems requiring community wide action. On the one hand, commendation is due the many adequate though extremely poor mothers. On the negative side, it is not inconceivable that as the stresses of poverty continue to bear upon them, the adequate mothers of today's study may be the neglectful ones of tomorrow. A sound program of prevention would seem to have as an imperative the availability of supportive child rearing services for all of these women even those not currently considered problematic." This is the essence of a community wide approach.

Also, since the problems encountered by families are of a wide variety, there is no one type of program that will meet everyones needs. Thus, a mix of services will be needed in any community wide approach. This is well stated in a recent report of a ten year follow up of a family support intervention in New Haven, Conn. (Steitz et al, 1985): "As many researchers have documented there are many reasons why a parent's capacity to nurture may be compromised. Living in a stressful environment, having limited support available from others, lacking knowledge about what is normal in child development, having babies who are unusually difficult, and having received inadequate nurturance themselves may all cause parents to be unable to support their child's optimal development. Intervention programs that address any of these problems are likely to result in benefits for children and families. Programs designed to address combinations of problems are likely to be even more effective . . . .

. . . For this reason, we would argue that comprehensiveness and coordination, of all services likely to be needed should be a cornerstone of family support intervention. While a laboratory research paradigm might suggest attempting to separate components in order to contrast them (e.g., day care for children vs. home visits for parents), in our opinion, that is not a promising research strategy. Attempting to determine which component of a program is most important may be akin to testing whether surgery is more important than medication in treating illness: . . . In the present project, utilization of the day care and home visit components was negatively correlated, reflecting the fact that what one family needed was not necessarily needed or wanted by another. Also neither component alone significantly predicted any later outcomes . . . . What remains to be accomplished in future research is the clarification of many issues of program design, targeting, and timing. But what no longer seems in doubt is that intervention can be implimented that can greatly enhance parent and child development in families at high risk and that the cost of failing to do so is high in both financial and human terms."

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Report of the Maine Delegation

1. Presentation by John Serrage

My name is John Serrage. I am the Director of the Division of Maternal and Child Health in the Bureau of Health in the State of Maine.

Current Status of Families in Maine: Maine is a large, mostly rural state, with low income people scattered in urban and rural settings. The total population is one million. There are 16 counties which range in population from 225,000 in Cumberland to 18,000 in Piscatoquis. Many of the states poor are isolated from health and other services. Most of the states population has been stable over the last 10 years except that people are leaving Maine's two most northern counties, Aroostook and Washington, and people are coming to Maine's southern and coastal counties, primarily York and Lincoln. There are 38 people per square mile in Maine as compared to 200 for New England as a whole. The unemployment rate is highest in the large northern rural counties (8.6 and 9.8%) and lowest in the southern and coastal counties (2.7 and 3.7%). I will give you an overview of some of the status statistics that I have. I have a lack of knowledge about the social service side of the system and the person who was supposed to present that is not here. Of the areas asked for: pregnancy outcome, rates for hospitalizations of children under one, child abuse, injuries and developmental status, we have most of our information on pregnancy outcome. The state probably has child abuse data. I am not familiar with it. The injury data is lacking for the most part except that Maine has high rates of death in children from fires, drowning, suicides, and auto accidents. Neither this data or hospitalization data has ever been analyzed for the purpose of prevention that I know of. Child development data is also not available but there's much more activity in this area and I think that one can make an assumption that this is where the real gains are to be made in improving the ultimate outcome. That is, the passing of the child into a happy, successful adult. Perhaps the other two speakers can say more on the developmental status of Maine's children and the plans to influence it, but I will speak on the health status of Maine's children.

Maine's fertility rate (1984-86) is essentially the same as the national average (62.7 births per 1000 women age 15-44). There are 16,000 births per year. Maine's teenage pregnancy rate (13.1%) has been stable for the last 10 years but it is still the 9th highest in the United States for a white population. In 1986 there were 3000 teen pregnancies. Eighty-two percent of Maine's pregnant women begin prenatal care in the first trimester but only 60% of the 600 teenagers between 15 and 17 years of age began care that early. These figures have been rising slowly but steadily over the past 10 years but they've dropped slightly in the last year. Only 4% of Maine's live births receive no or third-trimester care only. Twenty percent of Maine's births are born out of wedlock; a figure which has continued to rise. Sixty-one percent of the babies born to women under age 20 are out of wedlock; a figure which is rising even faster. The low-birth weight rate is 5.1% for the population as a whole. It is 7.7% for all ages if out of wedlock, and 6.9% for all births to teenage women. From this and other data I do draw a conclusion, I'm not sure how valid, but there appears to be a greater risk in singleness at any age for low birth weight than in adolescence. On the other hand, the highest risk is in the unmarried adolescent in which the low-birth weight rate is 8.1%. There is the usual relationship in Maine between the onset of prenatal care and low-birth weight. For 1986, the neonatal death rate is 5.6%, the infant mortality rate is 8.7%, and the perinatal death rate is 11.4%. This latter rate is based on using 20 weeks and 28 days for definition. The major causes of infant death are: low-birth weight, congenital anomalies, and SIDS. The percent of home births in Maine is one percent and that figure has been constant for the last 10 years. The figure for other out-of-hospital births is another 0.5 percent.

Organization of State Government for Services for Woman and Children: Financial assistance for women and children (AFDC) is in the Bureau of Income Maintenance, medicaid is in the Bureau of Medical Services, well-child, prenatal, and family planning programs are in the Bureau of Health, and child abuse and neglect and subsidized day care are in the Bureau of Social Services. These four bureaus makeup what we call in Maine the Department of Human Services. Headstart, on the other hand, is in the Office of Community Services which is a cabinet level position.

There are 20,000 day care slots available in Maine. To relate that to need, there are 16,000 births per year. These slots are available in 180 registered day care homes, 757 licensed day care homes, 166 day care centers, and 288 nursery schools. I'm not sure what the difference is between a registered day care home and a licensed day care home but there is a difference. Of these 20,000 children approximately 3,000 are subsidized by the state. The eligibility level for subsidized day care is anybody with income up to 115% of Maine's median income which is an income of $422.00 per week for a family of 4 ($21,944 per year).

As far as local services, most of Maine is governed as one large community and there are not very many subdivisions of significance. There are, I think, three cities in the state that do have their own health departments but other than that everything is dealt with on a statewide basis. There have been many task forces on specific subjects related to women and children over the years but there is no permanently sitting task force addressing families.

Primary Prevention in The State of Maine: This centers around four areas: parenting education, teenage programs, preschoolers at risk for developmental difficulties, and home visitation. I'm only going to touch briefly on these. The first major area is *parenting education*. The Bureau of Health has sought to promote parenting education throughout the state in three ways. The first is by training and encouraging people to teach parenting. We have provided training programs and certification. We've also urged the child birth education people in the state to take up parenting education as a sideline.

(*Manoff*) Where does this teaching the parent take place?

(*Serrage*) It's usually in a local Holiday Inn, I mean it's around the state.

(*Manoff*) It's not in an educational facility?

(*Weil*) No, except in a few cases.

(*Chamberlin*) But it's paid for by the state?

(*Serrage*) Yes.

(*Chamberlin*) How often are you training?

(*Serrage*) We have a yearly program.

(*Chamberlin*) Are you working directly with parents or training parent educators?

(*Serrage*) We're encouraging people to teach parenting.

(*Manoff*) In the schools?

(*Serrage*) Usually in the community in large basements or whatever.

(*Weil*) But those people trained are providing training to parents. It's not as though no parents are being trained.

(*Pierson*) So the typical participants in these training sessions are day care workers, social workers.

(*Serrage*) And child birth educators.

(*Berry*) Do you teach a specific curriculum such as the Nurturing Programs?

(*Serrage*) We probably have started our own and we've brought in outside speakers. This year we are using an organization from Massachusetts called COPE.

(*Mongan*) Does the State Education Department pay for the training?

(*Serrage*) No, the Bureau of Health.

(*Manoff*) These people who are trained, they're not reaching more people. They're taking this training back to where they work and including this new information in the work they do with the people who are already coming to them. This doesn't give you greater outreach. Is that right?

(*Serrage*) Yes and no, some public health nurses, for example, were already doing that. On the other hand, there are other people who get this training who never did anything before and go back and start a parenting education course in the community where there was none.

(*Manoff*) What percentage would you say are new?

(*Serrage*) At least half of the people there.

(*Manoff*) And the total numbers trained are how many for the state?

(*Serrage*) We have nineteen teachers certified now.

(*Pierson*) But the participants do get certified?

(*Serrage*) Yes, we do that because we also pay them to deliver the education, so we want to only pay the certified teachers.

(*Pierson*) Is there any connection with a higher education facility.

(*Serrage*) The University of Maine has marginal connections with this. We're trying to get them to begin all sorts of things but right now they are not heavily involved in any.

Now the three pronged approach to parenting education: The first one, that we just talked about, was to provide a base of teachers that are available to teach. The second one is to sell the idea of the need for parenting information to the general public so that they would seek out the teachers. To do this, we have had, for the last three years, what we refer to, perhaps presumptuously, as a marketing campaign for parenting education. We have had television, radio, and newspaper/poster ads. We have had materials published that we have distributed through those ads to try to sell parenting. We have produced resource books for every county in the state indicating where parenting teachers are located and how to reach them. All these things are distributed to the best of our ability.

(*Manoff*) Any visible results to that effort?

(*Serrage*) Well, we get results from the television ads by people calling in and asking for the booklet.

The third prong of this attack is to provide reimbursement for those who can't afford to pay for the courses. So what we've tried to do is provide the teachers, create the interest, and then pay for the training. We will pay for the parenting education for any family with an income up to 172% of the Federal poverty level. We have just finished a great effort convincing the medicaid people that they should pay for parenting classes as part of the medicaid program and that is functioning now so that everybody up to 172% of poverty has free access to a parenting class. We've done some marketing research to try and find out first of all whether people believe they have a need for parenting education and second, whether they have an interest in getting it. I have to say that the classical parenting class for which you go one night a week or one night a month for six months or whatever, is not high on people's list of ways to learn about parenting. What they do say is that they want to get their parenting education primarily through television and reading materials and we are working on ways of dealing with that. We've talked about, for example, having a lending library of VHS tapes and that's a possibility.

Our second major focus area is on *teenage activities.* We support several teenage programs. The first one is to provide community sex and family life educators. There is a teacher of family life education and sex education in each county. That person goes around to the schools in their county, tells the school that they're available as a resource for the family life education/sex education course in that school. They will help the school design the course, and, if so desired, will come in and teach it which is what most schools have wanted. They will also work in the non-school community, although that's a lot less organized.

The second teenage activity is support groups for pregnant and parenting teens statewide. This includes finding that person a place to live, getting them a job, getting them a GED certificate if they need it, finding day care, and just general support for these people including parenting education classes and respite care. There aren't enough of these programs at this date but they are scattered very thinly over the entire state.

(*Serrage*) The third teen activity is peer counselling. We have a counselling network that the Bureau of Health also funds in the state. I guess now about half of the state's high schools have peer counselors in them. We pay for the training of the trainers and the trainers go out and train the kids who counsel the other kids. They're also functioning in an outreach capacity and we're trying to sell that program to the rest of the high schools.

A fourth teen effort involves two *school-based health centers* in the state that are piloted for three years. They have been functioning just for the last six months. One is functioning extremely well, the other is just getting started. In addition to the those two, we have two pilot *school-based day care centers* in which we have a day care center in the school for the benefit of the teen parents. In the one functioning the longest, all the girls that had dropped out the year before came back with their babies. Now they don't drop out at all. They just stay in school and I'm very pleased with it.

The third major program area involves *preschoolers at risk for developmental difficulties*. Preschoolers at risk benefit from an interdepartmental effort which is a statewide network of case management agencies that do PR about the effort, screen, counsel, and case manage. These are in turn overseen by a state interdepartmental committee. This committee has also recently become the council which is mandated under 99-457 public law and is expanding its activities from the 3 to 5 down to birth. We're also expanding the program to include children at psycho-social risk as well as those established handicaps and moving toward a more community wide focus. The other two speakers will be able to speak much more fully about this interdepartmental effort.

(*Manoff*). What's the substance of the services provided for preschoolers?

(*Serrage*) This is a statewide program but it varies from region to region because it is locally controlled. There are people who try and find preschoolers who are having problems, either by going to the physicians in the area or advertising on the bulletin boards of supermarkets, or whatever. They try to find kids who are not developing normally and get their parents to bring them in for assessment and get them into an infant stimulation or preschool program to prepare them for school entry.

I've discussed three of our relative successes. The fourth item that I have on my list which is *home visitation* is not one of our successes. It's an incomplete task. We have not been able to organize and coordinate the numbers of people who are making home visits in our state. There are too many agencies, too many turf problems, and separate sets of rules that we've run into to try to deal with this. In general, the people that are making home visits now in our state all by themselves are public health nurses, child development workers, AFDC workers, and EPSDT workers. All these people go into the home and, as far as we see it, they could organize to go into different homes and spread their services to a wider population but they don't. They could organize to give one message and they don't. These workers come from the Department of Mental Health, the Bureau of Health, the Bureau of Medical Services, and the Bureau of Social Services — four separate agencies which is the reason for the lack of coordination.

Key Pieces of Legislation: For historical reasons, I'd like to say that the two at the federal level that have improved service the most in our state were the Block Grant in the first place and secondly the Jobs Bill. Both require supportive local administrations which we had and the Block Grant allowed the state to design its own program. The Jobs Bill infused a large amount of money into the state without any strings attached to it and it allowed us to do something new which we did. We began our prenatal reimbursement program with that Jobs Bill and it was one of the most successful things that we've done in recent years. At the state level the legislature has stabilized funding for prenatal care, for child development clinics, for genetic services, and for community family life education by allocating permanent state monies to those particular services. The prenatal care reimbursement program is for persons not covered by medicaid up to 172% of the Federal poverty level. The child development clinics are funded in part by the Block Grant and in part by permanent state money. Genetic services are likewise, and the community educators that I mentioned before are also funded by state money.

Other non-budget bills include the one that organized the interdepartmental committee that I referred to for preschool handicapped children which is mandated by the state legislature and our recent K through 12 school health education mandate. We now have a state law which requires school health education K through 12. There are 10 subareas that are covered, including family life education. It cannot just be a course given in the 5th grade or 11th grade or whatever, it's got to be spread out over K through 12 and there will be an army of investigators going out all over the state to make sure that it's done correctly.

The final thing is the new governor's child-care initiative. What this is suppose to do is produce six regional resource centers to urge the expansion of day care, to raise the awareness of the need for day care, and to provide technical assistance for those who wish to provide day care in the community. These six resource centers are in the process of development at the present time. This was funded through the legislature this past session.

Problems Encountered: I've been listing problems along the way and one I've already mentioned was the problem in organizing home visitation services. Another major problem we've had, and that's one of the main purposes for this conference, is to create an interest in primary prevention and the community wide prevention activities being discussed at this conference. We need to create an interest among other state administrators and the public. Someone from the new administration and someone from the legislature were supposed to be here from our state to listen to this discussion and to share in it and this has been thoroughly thwarted by circumstances. In fact, we now have an even more serious problem in our state. The new administration has not decided yet whether the Health Department should even be proactive as opposed to reactive. And so for that reason I have to leave the meeting early in order to get back and try and help set the goals for the future.

Report of the Maine Delegation

2. Presentation by Jane Weil

My name is Jane Weil and I work with Project Aims at the University of Southern Maine. Aims is a federally and state supported project looking at emotional and psycho-social risk factors for infants and young children and their families. Steve is going to talk about that a little bit more because he's on a team working with Project Aims. I've been involved with Maine's services to preschool children with special needs for about 15 years and will speak to a few of the other questions that were asked of the state teams.

Government Programs Available to Provide Subsidized Educational Opportunities for Non-handicapped Preschool Children ages 3, 4 and 5? About 4 years ago the Maine legislature appropriate nearly $2 million to expand Head Start in Maine with state funds; one of the few states at that time to have done that. I have copies of a report that I worked on regarding that expansion. This allowed a third more children to be served by Head Start, which is about 25% of those eligible. The national average is about 20%. So that is an important new service to some children in the state that was not available before. It allowed new Head Start Centers to be started in about 20 communities.

Question: What is the definition of eligibility for Head Start?
(*Weil*) The Federal poverty level. There is also a federal allowance that 10% of those admitted can be higher income children. There is another mandate at the federal level that 10% of the

children served should be handicapped. So they are a significant service program for handicapped children.

The preschool coordination system, the interdepartmental system that Dr. Serrage mentioned, is one that has a very interesting history in the state I think. I have a one page summary of the growth of that system (found at the end of this report). What I think is exciting about it, is that it's fully state funded. It is, I think, a very good example of 'interdepartmental' working together. It involves our Department of Education, Department of Human Services of which Dr. Serrage is a part, and our Department of Mental Health and Mental Retardation. There's a state counsel that Dr. Serrage and I are both on that includes representation from those three state agencies, three parent representatives, Head Start is represented, now the Maine advisory committee to special education is represented, and a consumer organization called The Association for Young Children with Special Needs, which is the advocacy group that really got the whole system underway. That system has grown over about a 12-year period. There were three pilot programs in three counties initially back in 1977 and from that the system grew over time until there are now 16 coordination projects in our 16 counties. The key person is the coordinator. Each of those projects is headed by a coordinator who organizes child find, child screening, and child service development efforts on the behalf of individual children. So the mandates of public law 94-142 and now the mandates of public law 99-457 are carried out through these coordination systems. It is within these systems that programs for individual children get developed with parent participation. Each coordination site has some dollars to buy services for children that they themselves do not provide. They are not primarily direct service organizations but coordination organizations. The amount of direct service they provide varies widely across the state. They are locally controlled. Their funds have tended to be handled by school districts but they have governing bodies that have the right to hire and fire the coordinator as opposed to the school board, so they're quite independent organizations. If a child, for instance, needs physical therapy and there's no other way to pay for it, the project can use some of its funds to pay for that physical therapy; or if a child needs to be placed in some kind of a group program and the only thing available is a nursery school that charges a tuition and the family can't pay for it, the project can pay for that service. Now with 99-457, the new federal law that has been passed this system is going to expand from a 3 to 5 year old system to a birth to 5 year old system. Each state under that federal mandate has the ability to define at risk and developmental delay in its own terms and the direction that our interdepartmental committee is moving in, I think, is to have some quite broad definitions regarding at risk and delay. So I see those 16 coordination projects as a very good way to provide early services to children who do not have an established handicap and whose problems are much less clearcut. There's a lot of service that's provided to families and a lot of parent education that goes on either through home visits or through encouraging parents to become involved in classes or group programs. A number of the projects provide parent support networks and through that system and through some other things in the state, I think there's a relatively active group of parent advocates who come to lobby the state legislature. I think there are efforts in the state to increase the sophistication of those parents and increase their willingness and their understanding of the system and ways to impact it.

Another question that was asked was about "Funding for the Primary Prevention of Child Abuse and Neglect." There are also child abuse and neglect councils in Maine and I think we now have 16 of those. A few of them serve more than one county and some of them like the one in Portland serves the city of Portland, so they aren't all by county lines, but there is now, I think, statewide coverage. We have a strong history in Maine of local control and so this system also has boards of directors that come from the community. They get funding primarily from the Bureau of Social Services within the Department of Human Services but they each do local fund raising. Their primary function is prevention rather than treatment. They work on that in their own communities to raise the awareness of child abuse and neglect by trying to bring in conferences and workshops for workers in the community and families on how do we prevent abuse and neglect.

Another question was asked about what other parent education and support programs such as parent drop-in centers are available. There is a parent drop-in center in Steve's community which he may be planning to talk about. What I wanted to say about the funding for these is that they are largely funded through purchase of service contracts with various parts of state government. The Department of Human Services, particularly the Bureau of Social Services and the Division of Maternal and Child Health put out RFP's for various kinds of services including parent education. The other major department that gets into that is the Department of Mental Health and Mental Retardation which also has a purchase of service capacity. There's a very strong history of private agencies in Maine which exist on a number of contracts that they might have with various parts of state government so that together an agency may provide services to preschool handicapped children, do some things around teenage pregnancy, do some of that through center based programs and home visiting programs, work on prenatal issues and do all of that with grants and contracts from various parts of state government and local fund raising.

I want to just briefly comment on the two pieces of legislation that Dr. Serrage mentioned. The school health education requirement came as part of our school reform act at the same time as the Head Start money was appropriated. It's taken a few years for those reforms to start working their way into the school systems but there is an active school health education coalition in our state that is, I think, working to see that the school health education requirement in that law is followed. There's a lot of activity now going on in the school health curriculum including the family life education area. A lot of schools are resistant and a lot of schools don't know where to put it. How do we teach family life from K through 12 and do it well and who is responsible and all those questions, but it is being dealt with more and I see that as something that will eventually not be such a controversial issue as it has been.

Some of the school based health centers that are getting started in Maine are doing very well. I'm familiar with the school that's running the day care program where all the girls are back in school and that's being run through the Home Economics Department. The teacher is excellent. She's been in that community for a long time, she's trusted, and I think it's working very well. Last year there was a family support bill passed that was initiated, not through our Department of Mental Health and Mental Retardation, but through advocacy groups associated with that department and the funding that was passed will be administered by that department. It was an important bill because the primary testifiers of the bill were parents of handicapped children. They were there to talk about the needs for respite care and other kinds of supports for parents. I'm told they made a tremendous impression on the Appropriations Committee who set up a specific task force to investigate why these services were not forthcoming from the Department of Mental Health and Mental Retardation. A small amount of money was appropriated but I think it was a foot in the door for the whole family support concept which is a relatively new term for our legislature to understand.

The legislator who could not be here, Charlene Rydell, came into the legislature as one of those coordinators of preschool programs so she brings a very interesting perspective to the legislature. We talked on the phone and one point she would have made if she could have been here was there have been some requirements in our state that high level departmental people come and testify rather than more mid-level bureaucrats who have a real working knowledge of programs. She said she would recommend that this policy be reviewed at the state level because there's a need for mid level bureaucrats to testify before and work with the legislative committees on specific pieces of legislation. She said don't send us a deputy commissioner who doesn't know anything about the prenatal care program when we're working on a specific piece of prenatal care legislation — we need bureaucrats who really know what's going on in that program to help us shape a bill that will do what we want it to do.

In the marketing campaign that went on around parenting, I think, from the feedback I've had, there was a very successful magazine called 'Maine Parent' that the Department of Human Services funded that was distributed through supermarkets and everywhere. I have heard it's one of the things parents could call in for and have sent to them. They could also pick it up all over the state. It was very well done, glossy, you know, not a pamphlet. I've heard repeated requests for that kind of thing to be a standard procedure from the department. I'm not sure if that's feasible but it was very well received from both within the worker community and the community at large.

(*Manoff*) Who put the magazine together for the department?

(*Weil*) It was a health educator within Dr. Serrage's bureau and I wish I had a copy with me because I'd be interested in your views of it.

The last question was "What Are The Main Problems That You Have Encountered in Trying to Implement Programs to Strengthen Families?" I think my response to that would be the general lack of public knowledge about parenting and child development. Across the board, you know, very well educated friends of mine, who recently adopted a child know nothing about child development. They're having as much trouble raising this infant as a low-income single parent. Their lack of child development information is just phenomenal. Parenting and being a parent is something we don't teach people about. I guess there are some new shows on television this season where babies are a central focus. But in the general media we are not struck often enough by being parents and the kinds of messages we get through the media about families are often very skewed so I would say that that is a pervasive problem, probably nationally.

(*Chamberlin*) One of the things that bothers me is the approach in which you start off with a program for handicapped kids and then expand it to cover those at environmental risk. It seems to me this medicalizes the intervention because the programs become staffed by therapists who have been taught a therapeutic orientation. It seems to me that the Headstart model in which you start with a general program and then add special services for kids with special needs is a much more appropriate general model to promote development.

(*Weil*) I would tend to agree with you. However, in Maine, although it did start out with handicapped children, the coordinators do not tend to be medical people. They tend to be early childhood educators and child development people. I don't think there's a therapist among them although they contract with therapy services. Increasingly, they're getting to be administrators and managers as new people are hired and I would say in general that the system has had an inclination to serve every child that seems to need it. In other words, to interpret handicap very broadly.

(*Chamberlin*) But you're still starting from a handicapped base and expanding out and it seems to me what you ought to have is basic services for everybody and then special services for kids with special needs as in Scandinavia and other countries.

(*Weil*) I would agree that that's ideal and I think the expansion of Head Start in Maine is a small step in that direction. However, I think the local people in the community know more about services to young children through the coordination system than through Head Start. Head Start, unfortunately, because it's always been a federal program, is known by the people it serves but it's not known by the community in general. I think it's got an excellent base to start from because there are all those people out there associated with Head Start who are used to advocating for it at the federal level and they've saved it time after time from funding cuts. That advocacy energy could be turned to focus on state legislatures as well. Unfortunately, in Maine we didn't have to fight for this expansion of Head Start. It came as part of the school reform bill. It was a small amount of money compared to the total package and the Head Start advocates were almost behind rather than ahead of that effort and so that money came to us fairly easily. Other states are really having to fight to make that kind of effort and I think that is a base to start from. The problem with Head Start is that it is seen as a low-income program. So for those of us who want to see community wide services for everybody, Head Start has that stigma of being a low-income program. However, I think the man on the street who is asked about Head Start doesn't necessarily think of it that way. People tend to say, 'Oh yes, that's some kind of good program for little kids.' But when one starts to look at it carefully people are going to say, 'well, that's a low-income program,' so it has some of the same disadvantages from that perspective I think.

(*Bauer*) To respond to your question from my view of one preschool project, it may not be an improvement on what your portraying it as, but it's slightly broader. That is they're not going just from a handicapped prospective but looking at it as an "at risk" sort of thing.

(*Chamberlin*) But that's still a deficit model. You have to accept yourself as being at risk. It's like the child abuse programs. In order to get services you have to say you've failed as a parent and you're about to abuse or neglect your child.

(*Bauer*) Actually, as construed our program isn't presented that way. I think it functions that way but the preschool program is offered to everyone. Everyone who is born at the hospital has contact with this program and has one visit from a program representative if they agree to it. It's not presented to families as an "at risk" model with that categorization and stigmatization. In actuality, most of the efforts end up being applied in an "at risk" method broadly defined to include psycho-social risk. However, in its presentation, it's more of a universal model open to everyone.

(*Chamberlin*) And the child abuse program, do you have to admit that you're at risk for child abuse in order to access those services?

(*Weil*) Most of their activities are not directly service oriented. They are community education and community outreach rather than a service to a particular family. They're really working on a prevention model so it's a lot of public education and public awareness.

(*Chamberlin*) Can you access subsidized day care for families that are experiencing a lot of stress without having to say that they're likely to abuse on neglect their child?

(*Weil*) In the 16 preschool projects around the state, they all have their own names. There's one called First Step, there's one called Co-Step, there's one called Opportunities. The word 'handicapped' is not in the name of the project and I think in large part they're seen as available to anybody but they are not coming from the place that you'd like to see them coming from and I would like to see them coming from that place too.

(*Bauer*) In our defense, though, that's not our fault. The federal government is the one that sets the rule for that.

(*Pierson*) Did you say that the school was the fiscal agent for the 16 coordination projects.

(*Weil*) That was a requirement in the beginning. And then there was a site that couldn't find a school that would do it and so that's been relaxed but in most cases schools have been the fiscal agents but the local coordinating council controls how the money is spent.

(*Pierson*) So it's strictly a pass through. Is the school taking a leadership role in any of your 16 models?

(*Weil*) Not to any great degree. That would be encouraged insofar as a local school district might be running a center based preschool handicapped program of some kind, but I think there are only 28 schools in our state that are doing that.

(*Pierson*) For all 16 models is it open for all children, birth to kindergarten? Is that what preschool means?

(*Weil*) It started out as a 3 to 5 system. Then about 4 or 5 years ago pilot projects to identify risk, delays or handicaps at birth were started in two counties. Now with 99-457 the whole system is going to become a birth to 5 system with individual family service plans developed for all children birth to 5. I think we're the only state that submitted a state plan for a birth to 5 system as opposed to a birth to 2 and a 3 to 5 system.

(*Papiernik*) Your interest begins at birth and the only prebirth system is also high risk related only to the teenage pregnant girl.

(*Weil*) Primarily.

(*Papiernik*) I see that you have not integrated these with obstetricians yet and to that I would propose that programs would begin during pregnancy or maybe before pregnancy. This is what we have done in France. Not to deal only with babies at risk but to reduce the numbers of babies born at risk in a given community. This is really the only thing to add to your program.

(*Bauer*) In the preschool project in our community, it was realized early on that everything you said is exactly true and that it makes little sense to arbitrarily say you start your services at birth. Therefore, our program has moved into the prenatal area so that the 0 to 5 project actually is beginning services during pregnancy and has made liaisons with the physicians who are delivering babies. Again it's limited by being a "high risk" approach. Their involvement is with mothers who have been designated as having problems generally by the physician who is taking care of the pregnancy or by public health nurses and so it's not population based. However, it's a step beyond waiting until the baby is born when there are already manifest stresses and strains that can impact on the outcome of the pregnancy. So the preschool program is at least moving in that general direction and it's been very successful and well received. The people who are delivering babies have found it very useful because they often perceive problems but had a sense that there was no particular way to deal with those non-medical aspects of the situation.

HISTORICAL DEVELOPMENT OF MAINE'S 0-5 COORDINATION SYSTEM for YOUNG CHILDREN with SPECIAL NEEDS

1977. The Association for Young Children with Special Needs (AYCSN) developed and found sponsors for 2 bills presented to the Legislature; one for mandated services for handicapped children beginning at birth; a second for services beginning at age 3. The bills were heard by the Education Committee which wanted to know what state and federal funds were being spent by the Departments of Educational and Cultural Services (DECS), Human Services (DHS) and Mental Health and Corrections (now DMH/MR) for these children. Agreement reached between AYCSN and the Committee that both bills would be withdrawn in exchange for the Committee issuing a Joint Study Order to the Commissioners of the 3 Departments. The Study Order required a report back to the Legislature describing (1) Maine's efforts on behalf of young handicapped children at that time, (2) estimates of numbers of children needing services and (3) recommendations.

1978. The report, required by the Study Order, was prepared and submitted back to the Legislature, by way of the Education Committee. It recommended that 3 "pilot" projects be funded at $50,000 each to coordinate, at the local level, the activities of the 3 Departments. DECS, with federal funds available to it, agreed to fund 2 more "pilots." A competitive grant process was established requiring the elements of Local Coordinating Committees (LCCs) be formed to write initial proposals. The basic membership of the state coordinating committee (the Interdepartmental Coordinating Committee for Preschool Handicapped Children or ICCPHC) was set out in this legislation. The first five projects were funded.

1979. Two more projects added with federal funds.

1980. An early childhood consultant added with state funds.

1982. Three more projects added with state funds. Total of 10.

1983. Four more projects added with state funds. Total of 14.

1984. Last 2 projects added bringing total to 16. All projects and early childhood consultant now supported with state funds. Also, permissive legislation passed allowing projects to extend coordination assistance downward below the age of 3, but not direct services.

1985. Funds from the Developmental Disabilities Council allowed expansion by three projects to meet needs in previously unserved rural geographic pockets of the state.

1986. The "Retirement Bill" was initiated to protect projects whose staff were part of the Maine State Retirement System.

Current With the passage of P. L. 99-457 (the amendments to the Education of All Handicapped Children Act) will require states to serve all handicapped children from the age of 3 by the school year 1990-91. It also allows states to initiate planning activities for services to infants who are handicapped or at-risk.

Maine has taken advantage of this federal legislation to do two important things: (1) establish ICCPHC as the state's applicant for the federal funds (rather than any one of the three primary state agencies, and (2) submit one work plan for 0-5 year olds instead of a 0-2 plan and a 3-5 plan. We understand Maine is the only state to have submitted a single plan.

Report of the Maine Delegation

3. Presentation by Stephen Bauer

The perspective I would like to give is that from the local level in rural western Maine, from the point of view of an agency that has been collaborating closely with the state programs and in many ways, I would like to think, has been instrumental in helping to move them along over the last 10 years. I've been a pediatrician in rural western Maine for about 10 years now. When I arrived there, I was just out of public health school and had been exposed to a number of the concepts that Bob Chamberlin has discussed here in terms of how we look at developmental services and preventive services. These ideas were starting to become disseminated around 10 years ago and it did not take me very long in primary care pediatrics in a rural area to realize that there is a good deal of truth to them and to realize that there were distinct limitations within the traditional medical model to what any physician could accomplish in terms of promoting the health and welfare of kids. There were two pediatricians at that point; the two of us shared this view and, as a result, tried to restructure our practice so that it took into account a number of these larger concepts, thus opening a whole variety of options.

What I'd like to describe very briefly is how that has evolved over 10 years and then describe Project Aims which is another way in which these concepts are hopefully going to have an impact at the local level.

About 10 years ago we changed a private practice of pediatrics into what is now called the Child Health Center of Norway, Maine. It was formed as a non-profit health and service agency within the region of western Maine. At its core is a fairly traditionally oriented private practice of pediatrics; traditional in the sense of trying to deliver high quality medical services to children, but non-traditional in its sense of the primacy of some of these population based factors and our hope to deal with them, as well as a very strong commitment to a developmental orientation. As other programs have been added, it has been useful to have that medical aspect integrated with the other aspects. There are not many health agencies around that I have encountered that have been able to integrate the medical/developmental perspective, which has its own set of rules and orientations, with the other community aspects. Bit by bit—in most cases with a good deal of help from the state and aided by the fact that there was a vacuum of services in our area at that time—it was possible to set up other programs as part of the Child Health Center. The first was an early intervention program with a fairly traditionally oriented multidisciplinary emphasis for children with a variety of handicaps. Over the years this has shifted somewhat from emphasizing children with established handicaps to those at "psycho-social risk" (children lacking development opportunities or exposed to high stress situations) because that is where most of the need appears to be in our area. We also have a community based nursery school as part of the Child Health Center which is integrated with the early intervention program so that it provides an opportunity for mainstreaming experience. It also places an emphasis on parent involvement in the way it runs and we use it as a model in that sense for encouraging parent and family involvement. Jane mentioned the parent support center which is one of our newer programs and which I think addresses most closely many of the concepts that are being discussed at the conference here. It fits into the broad category of a parent drop-in center. People can be referred by public health nurses, physicians or from a number of other sources to the program. It is a place with information on parenting resources and collections of parent education materials. It is staffed by a pediatric nurse practitioner and parents—in most cases mothers—can drop in during the hours that it's open. There is also a program of activities such as exercise classes, which turn out to be a very useful drawing card to get people into the whole thing. The exercise class has no fee charged and you can bring your child with you. It's been a place to offer support to families and that support offered to all families so that it isn't built on a "high risk" model per se (although people who are designated "high risk" can be referred and integrated into the model). I think it's been a very effective kind of focus for family support activities within the community. It was donated space originally. Currently, it's a redone barn at the back of the Child Health Center. It's space that is barely adequate. It's moved around because of the kinds of pressures you face keeping a program like this afloat in a small rural area that has uncertain funding sources.

(*Chamberlin*) Who does fund it?

(*Bauer*) It was originally funded by the state. There still is some money coming from the state, but it now also does its own solicitation of private funds. It's a hodgepodge of funding that is always somewhat tenuous, which is one of the stresses that goes with it, but it's been very well received in the community and addresses, at a very primary level, many of the concerns that we're discussing here.

(*Manoff*) I'm a parent and I'm living a stressful existence but so is everybody else . . . so I don't see any disease identification here—nothing wrong with me. How does the process start?

(*Bauer*) With the parent place? You mean, for instance, how would people come to be involved?

(*Manoff*) How am I told that I can get help for something that I'm not even aware I need?

(*Bauer*) Well there are a number of ways. A lot is more by word of mouth in terms of neighbor to neighbor contact. If your physician happens to be astute and has ways to pick up on the fact that you're stressed even if you're not announcing it per se, he/she can make the referral or give you the literature that describes it. If you see the poster in the supermarket that says 'Free Exercise Classes—You're Allowed to Bring Your Child' that might draw you in. If you happen to be visited by the public health nurse, she could mention it as a resource. More and more, I think, word of mouth is becoming important and I think that's the way that is most likely to give the information to the people who aren't referred through, having been designated as being "at risk." The other thing is, I think, that many people are stressed enough so that they are open to something of this sort if they become aware of it either by seeing the posters in the supermarket or by hearing somebody else mention it.

(*Manoff*) Do you share Dr. Chamberlin's concern about users having to identify themselves as having problems and their potentially shying away from it for this reason?

(*Bauer*) My feelings are complex. I find it hard to totally leave off a risk designation but I certainly accept the need for a population approach. And this program, I think, is a very practical example of the importance of that in that it is non-stigmatizing. There is a mixture of families who are designated at risk and those who are not designated "at risk," which in addition gives a chance for modeling. You may see families who are functioning better who can serve as models for families who are more stressed. Plus the opportunities for interpersonal interchange are really considerable, and I view it as very much of a self-help type of experience. Parents become part of the helping network there. They get very integrated into it. So it's parents helping other parents which I'm certainly becoming convinced is often more effective than professional help to parents in many cases.

(*Chamberlin*) I'm sorry Heather Weiss isn't here because she's dealt with this whole issue of the deficit model and what it means to identify yourself as having failed in some way in order to access services. It seems to me, for all these programs, that if they get the reputation that you have to have something wrong with you to participate, it will cut out a whole group of parents who are unwilling to designate themselves in that way.

(*Bauer*) That's what we have tried to avoid by offering things like the exercise classes, that are open to anybody.

Another thing that we have taken on is administration of the Child Development Clinic in our region, which is a state supported evaluation mechanism for children with a variety of handicapping conditions. More and more that model has also moved into the psycho-social realm, away from the strictly established risk. We have tried to take it a step further in a direction that is, I think, very pertinent to our discussions here; that is, we have tried very hard to integrate a family support model as part of the Child Development Clinic. We have viewed our mandate not to be merely generation of a diagnostic formulation and not to just suggest a menu of services for kids, but to also be part of the intervention process itself in the sense of providing family support, providing empowerment to families, trying to set the stage for letting families know that they can become case managers, treating families in a way that would promote this, and trying to emphasize the connections back into the community through the various people who may visit in the homes and be working with families. The aim is to promote and encourage a coordinated system. There's now a network of our state child development clinics and I have been trying to spread that message throughout the clinic system because I think it's an important orientation for all child development clinics, and one that traditionally in Maine and elsewhere hasn't always been emphasized.

It's also been possible to carry that same philosophy into our involvement with other groups in the community. Because the Child Health Center has a broad range of medical and non-medical concerns, we have become a focus for other efforts within the community. We have a very close liaison with the preschool projects, for instance, and I think to some extent we've been able to have a positive influence on their development, for example encouraging them to look more at the psycho-social aspects of problems and focusing further and further back toward the prenatal setting. We've had a close working relationship with the abuse and neglect council in our area in terms of raising consciousness on these issues. We have developed a close working relationship with the public health nurses who in Maine are extremely important because they are the closest thing Maine has to a home visitor system. They have a lot of presence in the homes of families, and the state of Maine has done quite a bit toward raising the consciousness of the public health nurses themselves in terms of broadening their scope of involvement beyond traditional nursing concerns. We've tried to maximize this philosophy in working with the nurses in our region.

And the final thing that this non-profit private agency has is a sense of being open to the future. If there are new approaches that come along, we are an established locus within the community with this agenda and we're available to apply for new grants when they became available. There have been other kinds of groups within other communities that have been able to be liaisons between community and the state. I think the advantage we've had is that we've been able to combine the medical and developmental perspective with these others, and I have found that to be a very useful model.

(*Chamberlin*) How big a community do you cover?

(*Bauer*) Our urban area is two towns of about 5,000 each. That's our central urban core. Various aspects of the program encompass various communities. Our largest catchment area per se would be the Child Development Clinic which serves a rather large tri-county area in western Maine. On the other hand, the

Parent Place, which is the drop-in parent support center, functionally services a much smaller geographic area.

(*Chamberlin*) Does the drop-in center serve the two town areas?

(*Bauer*) Yes, and a little more. I would say that our service base for most of our programs is the southern half of Oxford county (perhaps 15,000 people).

(*Little*) Is there an optimal size for a program such as yours beyond which you replicate rather than expand?

(*Bauer*) In a rural area I think the optimal size is different for different aspects of it. I think a child development clinic, for instance, is probably most effective serving a somewhat larger area, on a regional basis as opposed to a community basis. Some of the other aspects of it are much more effective on a very local basis. There are parts of our programs that have actually been replicated. The early intervention program has been expanded and replicated under our aegis to two other communities within our general area and I think that's been a good thing.

(*Little*) It's an administrative program decision whether replicated or expanded?

(*Bauer*) Yes, we have expanded within our region. We have in some ways become the agency in our region with the experience and the knowledge base so that within our region we are often viewed as having the background to be the logical agency to carry these things forward.

(*Chamberlin*) In Finland there's about one maternal and child health center for 5,000 population overall, with variations in size from urban to rural areas. The average size for a primary care health system is a population base of 10,000 to 20,000.

(*Papiernik*) How many births per year do you serve?

(*Bauer*) The hospital with which we are most directly affiliated has around 300 births a year. There's another hospital in northern Oxford county that has perhaps 200 births a year. A number of people within our general area deliver in Lewiston which is an urban area that has many more deliveries per year.

Our involvement is primarily at the pediatric level, and we have not maximized involvement, at least with our agency, at the level of obstetrics and prenatal service beyond what I've mentioned. When Bob talks about the maternal and child centers in Scandinavia I suspect that those are centers that encompass the obstetric and perinatal aspects more than we have. Our center grew out of a pediatric model because it was founded by pediatricians, and in some ways we have been trapped within that limited model in spite of our attempts to transcend it.

Before closing let me say a few words about Project AIMS.

This is a federally funded project in Maine to develop a tool that can be used to assess emotional functioning in young children and their families in a way analogous to other tools assessing developmental function or physical function. This project specifically focuses upon the emotional well-being of children in the family. Jane and I both have been working with the Core Instrumentation Team of the project to construct the tool. The instrument will be analogous to something like the Denver Developmental Screening Test but probably somewhat longer, combining interview, check list, and parent questionnaire. It is developmentally focused and very focused on family functioning, trying to take into account current concepts in the child development literature on both of those things. This tool is designed to be used in a variety of places: physicians offices, early education settings, preschool programs, day care and public health nurse programs. A variety of people could use it and then potentially come to a common way of looking at these issues in organizing their thoughts on them—hopefully in the same way that the Denver Developmental Screening Test has contributed to a commonality of approach that many have been able to become comfortable with. The grant is actually a 5-year grant and the first year or so has been taken up with producing the tool which will then be field tested. Once the tool has been tested there's a whole 2 to 3 years of the project that will be devoted to trying to get it implemented within the state of Maine beginning with pilot projects. The idea is to try to raise the consciousness of pediatricians, and family physicians within the state, encouraging them to look at this aspect of function and to try to foster the connections between the primary providers and the referral agencies and support groups that they would be using when they do turn up problems or concerns. This will give physicians and others experience on when and where to turn for help, and we hope will foster the creation of more direct services where most don't exist.

(*Manoff*) Are these indicators so complex that they couldn't be given directly to the public for which it is eventually intended?

(*Bauer*) The way it's been put together, it would be difficult to do it directly.

Report of the Vermont Delegation

1. Presentation by Patricia Berry

My name is Patricia Berry. I'm with the Department of Health in the State of Vermont. My position is titled Director of Local Health Services and Cheryl Mitchell and I will be presenting together. Cheryl is director of a private organization called the Adison County Parent/Child Center. We thought we'd divide our presentation into two parts, with me describing the public or state system and Cheryl going into some of the private agency activities. We thought we would give as brief an overview as possible as we want to tell you about the things we want you to know about but also want to leave a lot of time for you to ask us specifically about the things you're interested in. I presume you all know where Vermont is and what it looks like. Our population in 1985 was just a little over half a million, so in terms of its relative standing nationally, it's a big county. 7.6% percent of that population are children under 5. Thirty-five percent live in urban areas. Burlington is our largest city with about 38,000 people. And our 5th largest city is very nearby and is about 14,000 so Burlington is by far our largest city and the top 5 hover more around 15,000. About a 1/3 of the population lives in Chittenden County which includes Burlington. Over 99% are white and the remainder of that are blacks and Asian which are about equal in number. Sixty-two percent were born in Vermont so there is a strong attitude of who a Vermonter is. (For those of us who migrated into Vermont, we have to defend ourselves by saying the test is going to be to see where we die, not necessarily where were born.) There are only about 8,000 births in Vermont each year, representing a birth rate of about 15 per 1,000 of the total population. Because of our small numbers, a lot of our statistics are analyzed on 3 year running averages. Our most recent vital statistics are from 1985 and 1986 are due any time now. Of women who gave birth in 1985, 73% started prenatal care in the first trimester. This dropped about 10% from 1984 and that was due almost entirely because of a change in reporting. Prior to 1985 it was by mother's report. In 1985, we required the actual date to be taken from the medical record directly rather than by report, so now 73% is probably closer to the truth which is not very good. However, 93% of women are in prenatal care by the end of the 5th month and 96% by the end of the 6th month. And only 3% or 27 women in 1985 reported having received no prenatal care at all. So by and large women get some prenatal care in Vermont. Our infant mortality rate in 1985 was 8.5 and this represents the average over the past 5 years. Vermont has been very good in its infant mortality rate for a while now along with New Hampshire and I think some of that has been a result of a very successful perinatal program that New Hampshire and Vermont embarked on in the mid '70s. However, our low-birth weight rate has been running at a flat 6% for the last 10 years. There are variations among counties with Bennington County for example reaching 2.7% in 1985 and next to it up the road is Rutland County at 7.3%, so there are some interesting questions to ask about that.

In state government, there is the Agency of Human Services which is an umbrella agency in which the Department of Health is housed. Most of the other departments are housed there also. Welfare is a separate department. Mental health is a separate department. Social and Rehabilitative Services which provides child protection services is another separate department and then there are the Department of Corrections and some smaller offices on aging and alcohol and drug abuse. The other major service providers to children that are outside of the Agency of Human Services are Education which has its own separate department and reports directly to the governor. The Department of Employment and Training has recently become more involved in the training of young mothers and teens. As far as the Department of Health goes, we have 11 district offices which are part of the state agency and provide local public health services. Geographically, these generally serve a county with populations varying from about forty to one hundred thousand people. This is the system which I direct and in it there are public health nurses, nutritionists, and health outreach specialists who are paraprofessionals who mostly have human services background and then get specific public health training from us. We also have sanitarians and dental hygienists. By and large the staff deliver services out of these local offices. The Department of Health has about 340 employees, 150 of these work in local offices. The total Health Dept. budget is $21,000,000 and local health services is about $9,000,000 of which $7,500,000 is the W.I.C. Program representing about a 1/3 of the entire department's budget. I think this ratio is fairly consistent throughout the United States.As for the major programs that are delivered out of local health services I somewhat arbitrarily decided to describe them by funding sources. The first, which is the largest, is WIC and we have a participation of about 15,000 women and children. That represents about 85% of those eligible but, in fact, we have no waiting lists. We serve all six priorities and so in effect we serve all people who are eligible and seek and want those services. Vermont chooses to go to the upper limits of federal eligibility. In terms of income, that is 185% of poverty. One good reason for having a local system be part of the state agency was realized when W.I.C. legislation was passed. Rather than wait for a contracting cycle or try and get private agencies or even county health departments to think this was a good thing and apply, we overnight instituted a W.I.C. program in all our districts.

(*Albano*) I would just like to make a positive comment about Vermont and the WIC program because I was here in 1974 when WIC was just being introduced in Vermont and I don't know how that happened except I know that there was a senator in Vermont.

(*Berry*) Senator Aiken.

(*Albano*) Right, a U.S. senator who took tremendous leadership. For example in New Hampshire, we had 340 clients in W.I.C. and you had about 10,000. We've been trying to catch up ever since and we have finally 10 years later. But I think this is a key in the sense of legislative awareness to see a good public health prevention program and jump right in. I think Vermont deserves special recognition for that so I'd like to add that to the commentary.

(*Berry*) The other really tremendous opportunity in W.I.C. is that in effect we serve about 40% of all pregnant women and children under 5, so we know a lot of people and can make referrals to other programs. However, if the other resources aren't there, it's a tremendous stress to know all these families and not be able to provide the full gamut of services that they need.

(*Manoff*) How does the W.I.C. Program avoid the concern that was expressed here in terms of having to identify yourself as "low income" to get services?

(*Mitchell*) Vermont used a very good marketing strategy when W.I.C. was first starting saying to people: "Apply for W.I.C. even if you really don't think that you need it yourself, because you're going to expand the program which will ensure that the people that really do need it will be able to receive the food and services." Therefore, people were doing their public service by applying for this program and keeping it viable for everybody else.

(*Berry*) When we do get calls from people that are not qualified as far as income goes, we say come and talk to us about our well-child clinics or our home visiting programs and we can often link them up with one of these or other community services.

Our clinics are also very visible because our district offices are located in the population centers of that district. Clinics are held there and also at 3 to 5 outlying clinics. These are in local church basements, range halls, and the like.

Our next largest program is EPSDT (Early Periodic Screening Diagnosis and Treatment) which is a program that the state's Medicaid Program contracts out to us. We call it our Partners in Health Program and while we don't provide the clinical/medical services, we do provide outreach and education to families who have children 0 to 21 and are on Medicaid. We get the names of those families from Medicaid, and then contact them regarding our services. There's about 20,000 children on medicaid under 21, our case load at any given time is between 4 and 5,000. Because of limited resources we have to set priorities, but we do make contact with all these families and give them a basic piece of information and encourage them to utilize the best preventive insurance in the State of Vermont and that's the Medicaid Program. Unlike some states, there is an unspoken policy to encourage families with Medicaid to use the private sector. Whereas, our well-child clinics are attended by and large by the uninsured. In our Partners in Health Program, the staff goes out to visit families on Medicaid and talk about what is good preventive health care and ensure that they have transportation, which is a big problem in Vermont. This is often the reason why people don't keep up their preventive schedules, even though Medicaid does pay for this. So there is a lot of time spent in trying to establish systems of transportation. Another big problem we have is finding dentists. More and more are no longer providing care for children with Medicaid. Fortunately, pediatricians in our state are very good. However, while they get good pediatric care, probably the two screening pieces that we are not so comfortable with are hearing screening (because of the equipment that's needed for that) and a thorough developmental assessment because there's a wide variation of interest and skill in doing that among physicians.

Our third program is maternal and child health. This includes: 1) Well-child clinics that serve families who are uninsured and by that we mean uninsured for preventive services. Most people have "insurance" but most policies do not pay for preventive services. 2) Immunization clinics—we do have a school immunization law and so we assist school nurses insuring that kids in school are immunized. 3) Home visits—we do a lot of home visits. Primarily, it's public health nurses who visit pregnant women, newborns, and young children under the age of 5. In terms of numbers and level of services, the majority of home visits are in the newborn period. We have a long standing relationship with hospitals for newborn referrals.

Historically local health services began with public health nurses who have been out there since the 20's. Then along came W.I.C. and EPSDT in the early 70's and by the late 70's we were totally integrated. We cross-train all our staff and so that one day they may be in W.I.C. clinic and another day they'll be out doing home visiting and another day they'll be in the well-child clinic. And that's been very positive but in some ways I think what they call the central office has been remiss in identifying goals and objectives and giving feedback on whether in fact the goals have been reached. In trying to do better planning and using the Surgeon General's 1990 MCH Objectives, a few of us analyzed Vermont's data and found it was clear that we were doing very well in saving babies once they were born but not doing perhaps all we could in trying to optimize pregnancy outcome. In W.I.C., we were seeing all these pregnant women, but the W.I.C. Program only requires one visit. Once you get certified the W.I.C. Program doesn't require you to come back until after your baby is born. At that visit there was not a formalized protocol to determine risk situations and then to follow that woman through her pregnancy. Dr. Papiernik had been in Vermont at about the same time as we were undertaking this planning process, stimulating people on these issues and convincing us we needed to do more in preventing low-birth weight babies and improving pregnancy outcome. Our priorities have since shifted and we have a formal program we call our "prenatal initiative." Now there's an opportunity cost here. We will not be able to visit all newborns or particularly kids 1 to 5 but, unfortunately, the line has to get drawn somewhere and we are now trying to focus much more on the pregnant women. We have developed a risk assessment tool as a combination of Creasy and some of the social factors Dr. Papiernik has described in his research. Again we are not able to visit all pregnant women. I feel strongly that everybody deserves public health nursing support in the pregnancy period as well as newborns and young families but resources are such that we have to draw the line somewhere. Our prenatal initiative is a 3-pronged approach: 1) Focusing on home visiting and case management services on pregnant women at risk, 2) working closer with local physicians to engage them in our statewide goals, and 3) mounting a public media campaign about the importance of prenatal care and the prevention of having a low-birth weight baby. The obstetricians generally have little awareness of what the county data looks like. They didn't realize, for example, that Rutland County is running 7.3% low-birth weight babies and the state average is 5.7%. Our staff tell us women by and large don't know that it's important to get into prenatal care early. A lot of them want to have a low-birth weight baby. They heard it was easy. So we need to get physicians to tell women to call in as soon as possible, and not say I don't care about seeing you until the 4th month when the pregnancy is well established, and letting the physicians know that we're here to help with the parts that are not their area of expertise such as working with them to provide the educational piece in helping change lifestyle and helping women to stop working when this is indicated.

With this new initiative our staff is stressed at letting go high-risk toddlers. It comes at a time when our protective services agency has said they are so overloaded with court cases of physical abuse and sexual abuse that they can no longer respond to the neglect situations or even what they term as borderline abuse. The Public Health staff is trying to optimize family development and SRS (Social Protective Services) is coming in at what they call blood and broken bones situations. The gap between the two is very concerning.

Just quickly, some other things that we provide are prenatal and parenting classes. We are starting to focus in on teens by working with the schools in providing on-site prenatal classes and parenting classes. One school is beginning to look at kids at-risk for pregnancy and trying to start support groups for these kids with our assistance. Other areas are child injury prevention which includes working with day care providers to assess the safety of these environments. We've had a long-standing fetal alcohol syndrome program that identifies women who report drinking in pregnancy and then we follow their kids for 5 years. We are working with our health promotion unit on instituting and advocating good heart healthy kinds of lifestyles for infants and kids. We follow up families that have experienced Sudden Infant Death Syndrome and this has provided us with some expertise in terms of grieving and we are able to follow all families that have experienced a child's death as well as a miscarriage or stillbirth and that's been a very good program. Healthy Start is a program in two communities that we started with Jobs Bill money. It is a broad based community service for first time parents. Public health nurses begin visits in the prenatal period and follow families through the child's second birthday. There's a fairly strict research side to this. We are into our 3rd year and winding down to end in the beginning of July '89 after which we will release our findings. Already, though, there is some interest in cloning this program statewide, but that would require a substantial amount of additional resources as it provides very intensive services.

Other programs outside of local health services are handicapped children's services and child development clinics; those are provided by Health Department staff who operate out of Burlington. We also have outside contracts to planned parenthood who provide the family planning piece of our public health system. We have a maternal and infant care project which is our only publicly funded prenatal clinic and that's in Burlington.

(*Jackson*) That's quite a list of programs and I'm just wondering whether you see those as distinct programs or do you see them more as all one program?

(*Berry*) Functionally, it's all in one. There are different program people to keep track of activities but it's all in one as far as delivery to clients. In each area, the team of the public health nurse and the health outreach specialist have a group of families and some of them may have a fetal alcohol syndrome baby or SIDS but these teams provide the full array of services.

Report of the Vermont Delegation

2. Presentation by Cheryl Mitchell

I'm Cheryl Mitchell and I'm one of the co-directors of a community based family education and support service that's been in existence for 8 years and also one of the founders of The Vermont Children's Forum, a state child advocacy group. I'd like to talk about three things.

First, I'll describe our community based system, how it evolved into a statewide network, how funding through the state legislature came about, and what the balancing act is that's going on right now.

Next, I'll talk about another program that started in local communities, the Adolescent Pregnancy Watch, which is now a statewide process. Finally we'll review quickly the legislation Vermont has enacted in the past few years that addresses some of the issues around prevention and family support services.

Our county wide program started 8 years ago as a broad based family support and education program. It is based on the theory that everybody who is pregnant or has children needs and deserves support and education. It is a program open to the entire community and a program working in a very rural area. We have 32,000 people in the county but some of the towns are inaccessible because of the mountains. Many of the people that we wanted to be available for had neither cars nor telephones and lived in trailers at the end of roads. We wanted a program that would reach people at home as well as provide center based services. We feel the three crucial issues in the program are self-esteem development for both parents and children, communication skills (we've had a remarkable number of parents who didn't talk to their kids when they were babies because the kids didn't talk and they thought it was a waste of effort), and developing a sense of community. Our feeling was that people without social support systems were at much higher risk than people who did have support. If they didn't have grandparents around or if they didn't have extended family around to support them, we could help people create systems for each other. Because of the way funding works, we started initially with limited programs open to the entire community and a strong focus on adolescent parents, and later with parents of handicapped children. We served 70 families during our first year of operation. The program now serves about 1,500 families in the county. We reached capacity after about six years and the number has stayed fairly level since that time. During the first two years our focus was only on Addison county. As other people saw how effective the model was, we received increasing requests for technical assistance. Last year we provided tours, workshops, presentations, and consultation reaching more than 4,000 individuals.

In general, primary prevention services are our major effort reaching about 1,200 families. Services include playgroups which meet weekly for an hour and a half, in the small towns. Most of the towns in our county have 300-1200 people in them. The playgroups take place in a church basement or a grange hall or a library. We haul in equipment for parents and kids. Groups are focused on children from birth to three but a lot of people bring older siblings with them. They are fairly informal. The emphasis is mostly on parents having an opportunity to talk with other parents. We have staff members there who can teach people new activities with their kids, who can screen children if there's a concern about their development and who can do a specific course if that's what parents want. But mostly what people enjoy is getting together with other parents, seeing what somebody else's kid looks like, and realizing that your child is not as outrageous as you thought. We have done these in nine towns. Sometimes groups are co-lead by staff from other agencies. Sometimes the Head Start teacher will be there, sometimes somebody from the mental health service will be there, sometimes people from the schools or the early education programs will come.

We also do formal parenting education classes because some people want them. However, they're less successful in terms of the numbers of people interested. We give courses for families of all ages. An exciting one, that everybody comes out for, is the prenatal exercise class. People want to be in shape and this turned into a very good educational program. But when we offered only talking about prenatal issues, people didn't show up. There's a post-partem group, one for parents of newborns, and a group for parents for each child developmental stage up through young adults. People did not show up for the parenting young adults courses. They come through teenagers and that's about it. Sometimes we use prepared packages like the Nurturing Program or STEP (Systematic Training for Effective Parenthood), and Developing Capable Young People. Usually we do the standard program once and then it gets modified based on the communities response to what's going on. We reach a fair number of people this way but I would say it's somewhat less effective than the playgroups in terms of really providing support.

(*Wallner*) When you have a program like that which doesn't work as well as you want it to work, are you set up to find out why it's not working?

(*Mitchell*) Yes, we usually ask people and then change it the next time. We found people did not want to make a 15-week commitment to something. What they really liked was to know what was happening each week, so they could drop in on the ones that were of interest to them without having to make a long-term commitment.

The other thing we learned was that most parents find getting together with other parents especially helpful. Factual information either on a modeling basis or by reading was also sought, but not as a straight curriculum such as a 15-week psychology course. That's not to say people don't come but, we'll have maybe six families sign up for a course whereas the playgroups may have 20-30 families at a time.

(*Chamberlin*) Do you do anything about providing transportation?

(*Mitchell*) We do. The outreach workers in our program all provide transportation to families who need it. We operate three vans pretty much full time so we can pick people up and bring them in. Now, with the new changes in Medicaid, the situation may improve. People on Medicaid can get transportation to courses paid for as well as to doctor's appointments. Although we don't have any public transportation in the county, private transportation has become much more available. We also teach people how to drive and help them get their licenses. Our mechanic teaches people how to maintain cars.

We teach family life and parenting in the schools. This is a course that includes a panel of teenage parents who come and talk to high school students about what it's really like to be a teen parent. It's part of a larger unit that focuses on prevention of pregnancy or thinking about issues in sexuality and on relationships between girls and boys. We talk about birth control, we talk about decision making, we talk about problem solving and coping skills. What people are interested in is 'what do guys want, what do girls want, how do I know I'm in love.' We put a strong emphasis on people avoiding being pressured into doing things that they don't want to do. That's not the kids' emphasis but it does seem to have some effect, especially when teen parents come in and say I thought it was going to be rosy and it's just very, very difficult. I can't party anymore because I can't afford a babysitter.

In addition to working with the students in four high schools, we do the seminars for their parents ahead of time. This gives them a chance to check us out and look over the materials that we're going to be using and ask questions. It often provides an easy basis for discussions between parents and teens of the issues we cover.

We provide community education events. We do baby olympics and family fairs and spaghetti suppers, and recreational activities that are aimed at parents and kids having fun together. These are open to the whole community and are very popular.

(*Chamberlin*) The spaghetti suppers and fairs are what you call community building?

(*Mitchell*) Right.

Another part of community building is that we operate in a network; that is, the different state agencies and the local agencies work together. The schools, the health departments, social services, welfare, employment and training, the counselling service, the private health community and the Parent/Child Center all work to make this a community that values and welcomes families.

(*Bauer*) Perhaps you could make it explicit what I think isn't there and what I think is an important point. It sounds like part of what you're doing is that there is the potential for people who do not have a peer group or don't have friends to develop at least the beginnings of friendships or a peer group or relating positively to the system through that sort of primary level thing. If that's true, it should be stated explicitly because I think it's an important bit of knowledge for us to be building on.

(*Mitchell*) It's building not just community structures but also people feeling that they are part of a community, that they have an important role in the community and that they have friends. You look at what people are looking for their children. They're looking for the same things for themselves. Basically, we say people want their kids to be happy, healthy, and nice which means have friends. It tends to be the same thing for parents.

We also do early intervention. This is primarily through home visiting and we do have an eligibility criteria for that. We'll visit anybody once who calls up and people usually call up at a crisis time. They usually don't just call up to say I'd like somebody to drop by but they are desperate for help and a home visit is often suggested. Home visiting tends to be one service people don't request for themselves. More often somebody else calls and says I think so and so really needs some systematic support. They need somebody to help them do some planning around what's going on for their family. We visit primarily with pregnant and parenting teenagers, families of handicapped infants and toddlers, and families where the parents have special needs. The parents may be emotionally disturbed or heavily involved in alcohol.

(*Bauer*) Is there a connection with Head Start?

(*Mitchell*) Our programs focus primarily on pre-birth to 3. Head Start, which is a home-based program, is 3 to 5. We'll usually come visit people until their kids are 3 and then, if they still would like that support, they'll transition into one of the other home visiting programs. Those other home visiting programs are Head Start, which in Vermont is almost entirely home based, Triple E which is essential early education services to families with handicapped children and that also is a 3 to 5 program in most Vermont towns and migrant education. Vermont is a very agricultural state. We tend to think of migrant workers as people who come from Jamaica to pick the crops. More often they are people who live and work on the dairy farms. The reason they're considered migrants is the typical amount of time that a family is on any given farm is about 5 months before they have a fight with their boss and they have to move. There's a huge pool of people moving around the state, not even around the state, moving around the county, but they don't have the stability of a place in the social system. Our mental health program is beginning to provide some outreach home visits. And, of course, if the child has been or is being abused, SRS does some home visiting. Actually they contract with us to do the home visiting for the 3 to 5 year olds.

We lead specialized support groups, for example, a support group for women who are being battered or a support group for parents of handicapped kids. Groups are often population specific as opposed to classes that are pretty much based on the age of the child. In fact, people perceive themselves as having a common problem rather than just having kids at the same age. It may be that the child is handicapped, it may be that they have been abusing their child and they want to stop, it may be that they are all children of alcoholics and they're now trying to raise children and they have some concerns about those issues. So that's early intervention and then we do have what is often called a Treatment Program.

We have a developmental child care center for kids birth to 3 and ideally it would continue to be a mainstreamed program. Our building has been deteriorating so we've lost a lot of space this year. We don't have as much room for kids. We provide developmental day care usually for children of parents who are onsite with us. The parents are there for a really intensive parenting support class that meets 20 hours a week for six months. Parents come 3 days a week with their kids and then their kids can come 2 more days if they want to. The focus is very specifically on parenting skills, child care skills, and on personal development skills. The tutors from adult basic education come to help people learn basic reading and writing skills or to take a GED if that's what they would like to do. We do sewing classes, car repair classes; things where people will make or do something concrete so they will receive a lot of positive feedback. We have a strong focus on basic pre-vocational and job training skills. The other thing that we use the developmental day care for is training. Typically, pregnant women (usually teens) who are really nervous about being parents, will come and work as volunteers in the day care to learn some parenting skills before their babies are born. Similarly, we encourage high risk high school students to come over. One of the terrible mistakes we made at the beginning was to have high risk students come and work with babies. They all thought it was so nice, they got pregnant. Now they come and work with toddlers and people delay their pregnancies until they're ready to be parents. We provide a fair number of other services onsite. We're a neutral territory for families where the child has been removed from the home to be in foster care; parents and the child can meet together here with the social workers in a supervised setting to work towards reunification. People from the Children's Aid Society can come and counsel somebody about releasing a child for adoption. We also do training for professionals, training for day care homes, and training for other human service workers. Our budget right now is 400,000 dollars a year and we have a staff of 20.

(*Chamberlin*) What kind of facility are you in?

(*Mitchell*) We're in a gorgeous old house that's rotting.

(*Bauer*) How did you start, how did you grow, and who supports you for that 400,000?

(*Mitchell*) It was a group of people in the community who felt that something more was needed. We have very good medical services in the county and most of the people deliver in the hospital here. They have good birthing classes and everybody got excited about their pregnancy. They did the birthing classes, they had the babies, and that was it. There was public health and that was the only good support service in the community for kids until they turned 3. If you stumbled through until your child was 3 there was Head Start and the day care system pretty much started at age 3. People in the community who felt that people needed more support during the time that their kids were young got together and said this is our dream. It would look like this: home visits, developmental center, and activities for parents to do together.

(*Bauer*) So all those things were present more or less after creation?

(*Mitchell*) Yes, pretty much. We weren't doing these small town playgroups at the beginning. We just had the center in Middlebury and the home visits and basically we hired a staff of outreach workers who went and knocked on people's doors and said: "Here we are to help you be a better parent, what would you like?" and people told us. We started with 70 families. Most of those families were referred in the earlier years by Adult Basic Education who said they'd been working with parents on getting a GED or learning how to read but the real issue was I'm losing it with my kids, what can I do? Then once we were going, the referrals came mostly from Public Health through the WIC clinics and from the school guidance counselors. We started with a federal grant, we started with release time from most of the agencies for staff time to do planning and supervision, with Title XX day care money from the state and food programs from the Departments of Education and Agriculture. We feed about 60 people three meals a day through the Child Nutrition Program. Now we have 17 different funding sources. It is a continual balancing act often dependent on one-year seed grants which make it difficult to keep intact your program and makes it necessary to learn the right words to say to be able to get the grant to keep your program going.

We found out that, once we had been going for a while and the program started to be successful in terms of better birth outcomes for the babies of teenagers and real reductions in child abuse and welfare dependency rates, other counties in the state got interested in doing similar programs. By last year there were 8 community based programs and each one is different. We banded together and asked if the state would support the program through line item funding. So there is now line item funding that provides about 25% of the budget of each of those programs. About 25% is from fees for services and then each community has a different mix to make up the rest. It may be United Way, it may be town general funds, or it may be fees for service.

(*Bauer*) Do you have a required match? In other words to match the state in federal dollars?

(*Mitchell*) The federal programs vary. The one that we had from the Office of Adolescent Pregnancy Programs was 20%, one from The Office of Special Education was 10%, and the State with their line item funding is requiring a 10% match.

(*Bauer*) How much state funding is the line item?

(*Mitchell*) The line item was 360,000, not major, but it certainly was a start.

(*Chamberlin*) Is fund raising a continual hassle for you? Does it require an enormous amount of energy?

(*Mitchell*) Yes, but we're hoping that now that it's somewhat stabilized it will be easier.

(*Weil*) I think that question about funding and keeping your funding going, it's just a major problem for administrators. I think when you've got examples like this of how well it works, you can make an argument for consolidation of that funding so that administrators time can be better spent on programs.

(*Chamberlin*) Every program I know like this has just this terrible hassle of trying to keep it funded.

(*Weil*) And your bookkeeping is a nightmare.

(*Mitchell*) Legislation was introduced last year but it didn't get voted on by the time the session ended. So our hope is that if it passes this year it will provide a mandate for the programs.

Somebody said if you're a line item, you're less secure than if you're buried in the budget but there are also some issues that do become vulnerable, like the Healthy Start Program that Pat was describing. Sometimes it really pays to have mandates.

(*Chamberlin*) There are 8 different communities now that are part of a network. Are these county based?

(*Mitchell*) They are all county based with two exceptions. One serves just the northern part of Chittenden County which is our largest county. One program serves three counties and that's the Northeast Kingdom of Vermont.

(*Berry*) But these programs don't look like yours?

(*Mitchell*) No, they're just starting. Most of the programs are about two years old so they don't provide that full array of services yet, although that's where they're heading.

(*Chamberlin*) Is this non-governmental network essential? Is it all community people who got together in these communities?

(*Mitchell*) Yes. Most of the programs grew out of a process like ours, people from different agencies and parents and health providers getting together. Some grew out of Head Start and some grew out of existing day care centers.

(*Bauer*) I guess I have trouble understanding how people coming together who have an interest get to the point of incorporating or having standing to even apply for a grant to get a foot in the door. How did it happen in your case?

(*Mitchell*) In our case, as in almost all the eight other cases, one of those people works for an agency that says, 'O.k., you can use our name as a funnel.

(*Bauer*) So it's the lead agency concept.

(*Weil*) And I think often the group fairly quickly knows about a pot of money to go after and if they get that grant, it gets them started.

(*Bauer*) But you piggyback initially on to a lead agency?

(*Mitchell*) You usually do. I mean, it would be crazy to give money to a group of people that don't have any track record.

(*Bauer*) When you said 'a group of people came together', there's a missing step there between a group of people coming together and then actually being funded.

(*Mitchell*) Right. Usually first it's sponsored and then it incorporates and separates out.

Child care in Vermont I think is similar to other states. About 60%, of our kids under six are in care out of their homes. Most of them are with relatives and in non-licensed and non-regulated places. A big change in Vermont was going from licensing homes, which was a complicated and scary process for people, to registration in which a potential child care provider simply says to the state 'I would like to provide child care and I'll follow your mandates! When this occurred there was a huge increase in the numbers of homes and registered slots available. The nice thing that happened with that change was the training programs that we do to support day care providers. We had a huge list of people who were interested in receiving ongoing professional development training and you knew their names and phone numbers. So now the state, at least for 3 to 5 year old care, is in much, much better shape than we were about 5 years ago. There's still a big problem of care for the birth to 3 child because it's so expensive.

(*Chamberlin*) Is there any incentive to get them to register? What do they get out of it?

(*Mitchell*) Somebody will turn them in as being illegal if they don't and you get free training. Until they've had some training, people don't see the value of it. They can also be part of the child care nutrition program which means if they're serving snacks and meals to kids anyway, they'll get reimbursed for it. That's a big financial boost but again it hasn't brought people in to get registered. The major reason is that someone they know and trust suggests it and they can then have their names given out through the resource and referral programs. If they want to fill their slots and have kids, they have somebody funnelling potential families to them.

Title XX is our major funding source in Vermont for state paid assistance for child care and it provides Children's Protective Service (free child care for kids whose families are abusing or neglecting them), Family Support Child Care which is 18 hours a week of subsidized child care for a family under stress, and Fee Scale Child Care which is a tuition assistance program based on family income for low income working parents and parents in training programs. The other thing that's happened in Vermont in the past two years is that there's money for child care in a program called SPOP which is the Single Parent Opportunity Program; it's to encourage single parents on AFDC to complete their education and get jobs. There's day care money in something called Reach Up which is run by a waiver through the AFDC program. Again there's child care money for people to take specific steps to get off welfare and there's a fair amount of Carl Perkins money around that supports child care for people who are doing educational programs. However, there are still people in the state paying more than 30% of their incomes for good child care which we think is outrageous. We got a 1.6 million dollar increase in our child care budget last year which doesn't sound like much of anything except that Vermont's entire child care budget was 2 million dollars before that.

(*Chamberlin*) Is that state or federal?

(*Mitchell*) That's state, general fund dollars.

That bill also pushed the training programs so that we had much better training available to the people, especially in the registered homes. And that's where the growth is right now. You very seldom see new day care centers starting up. We are starting to see employer supported day care but it's not going as fast as we would like.

(*Bauer*) The mothers of 60% of children under six are in the work force in Vermont. How does that compare with National figures?

(*Chamberlin*) Nationally, I think it's 50% of mothers of children under six are in the work force.

(*Mitchell*) It's a fairly comparable figure nationally.

I think because of time limitation, I'll just run through quickly some of the important legislation that Vermont has passed. The first one only happened in our state 5 years ago and this was banning corporal punishment in schools and in child care centers. It was a heavily contested bill. What was so significant about its passing was that it then said, 'our society doesn't believe in hurting children.' In addition, it provided a lot of training money for child care providers and schools around alternative means of behavior guidance and that had an effect on helping people who took care of children to work more closely with parents about the way they did behavior guidance.

Mandatory kindergarten only passed 2 years ago in our state. It was about a three year battle to get that passed, again heavily contested. Every school in Vermont will have to offer kindergarten by 1989 and most of them are doing it now.

Other significant ones two years ago were the Children's Trust Fund which provides primary prevention funding and the money that went with this was very small. The year that this passed they got a million and a half dollars in requests for parenting education programs. Under this project they were able to fund 150,000 dollars worth of it. It's now up to about 1/4 of a million and it's still a very small program but at least it's indicative of what people are thinking about. Last year an early education initiative was passed and this provides free preschool for children ages 3 through 5 for kids who are not eligible under Title XX or Triple E. It was funded at half a million and they expect that it will be funded at a million dollars this year. They expect to increase it half a million each year until all the kids in the state are served.

(*Chamberlin*) Is that in addition to Head Start?

(*Mitchell*) That's in addition to Head Start.

(*Chamberlin*) You don't have to be handicapped to get access to that?

(*Pierson*) Who can apply to the trust fund and the early education initiative?

(*Mitchell*) Agencies, schools, any community group. The main requirement on both of these projects is that to apply you have to have an interagency group that plans it. It could be a school, day care center, and a Head Start program cooperatively planning it. It could be a mental health center and a parent-child center and a state SRS program.

(*Pierson*) Who makes the decision about who gets funded and who doesn't?

(*Mitchell*) When this legislation passed, they developed something called the Counsel for Children and Families Prevention Programs and that group reviews the grant applications. It is composed of people from the different state agencies as well as private people.

(*Weil*) Is there a tax check off in Vermont? Is that how you get the money?

(*Mitchell*) No, I think it's ducks that we check off for in Vermont.

(*Weil*) We check off for both now in Maine. How is the money raised for your children's trust fund?

(*Mitchell*) Through general fund dollars.

(*Weil*) And what is the age range for that next program, the early education initiatives?

(*Mitchell*) The early ed focuses on 3 and 4's but it can go 3 to 5.

(*Pierson*) Typically, you have many more applicants than funding available. Are most applicants funded for a portion of their request or do certain applicants have full funding?

(*Mitchell*) In almost all of these cases, they select them for full funding and say let's use these un met requests as a way to drive the need for these programs.

(*Bauer*) Is that seed money that is time limited?

(*Mitchell*) The trust fund is three years. We hoped that it was not going to be time limited. The theory is once these are up and going they will be there for families supported by the local community.

Other significant legislation was Act 51 which is a Drug and Alcohol Abuse Prevention Programs in the schools. Interesting, is that so many of the issues are similar in terms of improving self-esteem and communication skills that it looks like a lot of the other prevention programs.

(*Berry*) Didn't this start out to be a family life education program but as Vermont wasn't ready for it it ended up a program to prevent drug and alcohol abuse?

(*Mitchell*) Yes, and now were hoping that we can add sex to it.

And then Act 79 which did not get a lot of notoriety but it was our primary prevention plan and it said, "All you state departments and state agencies please look at your budgets; we want you to guarantee that you're putting at least 10% of your money into primary prevention rather than secondary and tertiary." Because there's not a strong legislative mandate behind it, nothing much happened. Everybody looked at their budgets. The Health Dept. was doing it but nobody else was doing it and not much changed. But it's at least on the books. The other nice thing is that there has been a specific training program around primary prevention that has come out of that. Finally, an issue very important to me is we had a good landlord tenant Act that was passed last year that prohibited housing discrimination on the basis of people having children. I don't know if the other states are as bad as Vermont in terms of housing but it has made some difference and it also spurred a lot of the ecumenical groups then to get involved in the housing issue. We have problems in a lot of our communities as the downtown areas are becoming gentrified so that the old apartment buildings are going into businesses. We're now seeing church groups buying up those homes to keep them as low-rent apartment programs.

(*Weil*) Do you think having a woman governor had an impact on some of these initiatives? Do you think they would have happened otherwise?

(*Mitchell*) I would say a substantial impact. Not that she necessarily spearheaded them. An interesting issue for us as child advocates is that both the Governor and most of the people in the departments who were under such pressures just to maintain what they have, couldn't come out and advocate for new programs. However, they told us to go for it. And she did not veto things so then there was a huge ground swell of public desire for it.

(*Chamberlin*) Do you have an advocacy group that pressures the legislature to pass these kind of things?

(*Mitchell*) It's called the Vermont Children's Forum. Although it does do a lot of educating around legislative issues their belief is that budget drives policy in this state and so they place a lot of emphasis on saying, "look at how you're spending your money. Could you be using it more effectively to do early support services for people instead of dumping all this money into after the fact programs."

(*Little*) I have a question about the Vermont governor. No. 1, you may agree or disagree, but my observations would be some of the appointments she's made have been proactive rather than reactive and that's been very important. While she hasn't necessarily come out and supported certain issues herself the people that she's appointed have. It's been I think a very clear message. The other one, is there's been a budget surplus and you know Vermont's in good shape in terms of its budget.

(*Mitchell*) It makes a difference.

(*Weil*) I know the Children's Forum is a real important group to highlight. We have something similar in Maine called the Coalition for Maine's Children and it's the group that got the Children's Trust Fund bill introduced and passed in our state and they often are a broad based advocacy group that has got people from Health and Mental Health and citizens and you know it's a coalition that crosses a lot of lines.

(*Mitchell*) I used to be terrified about talking to legislatures. Basically, people said there are things that we want to do but our hands are tied . . . .

(*Little*) What happens with evaluations of children? What are your evaluation obligations?

(*Mitchell*) It depends on your funding sources usually. We have external evaluators come each year for the federal funding parts of our program which is the Teen Pregnancy part. The Children's Trust Fund also hires an external evaluator. That program has only been in effect now for a year so the results haven't come back in. When they line item funded the Parent-Child Centers, they hired external evaluators from the University of Vermont. They just completed a baseline this summer and then they'll come back each year to do that.

Vermont Children's Forum

1988
Children's Campaign
Agenda:

An Initiative for Children and Families

Report of the New Hampshire Delegation

1. Presentation by Charles Albano

I'll start off for New Hampshire, and give you a basic overview. I will also speak as someone who has been in the Bureau of Maternal and Child Health since 1974. I'd also like to preface my remarks that some of what I quote is from Vital Records and appropriate credit should be given to them. To put my presentation in perspective for this group I'd like to share with you what my daughter said to me this past weekend. I have a 12-year-old daughter, and on Saturday she invited another girl friend to sleep over. Her new girl friend (of 2 weeks) said to her, "Nina," for the sleepover, "should I bring beer and cigarettes?" To me that represents a lot of what we're talking about today in the sense of not just addressing issues for low-income or poor families; we're talking about kids from all socio-economic levels and I think what Bob is trying to promote, is to look at all levels of family interaction. The smoking, drinking, peer pressure, and family values are all represented in that statement.

First, let me share with you some State highlights. New Hampshire has just over a million people. It has grown 12% since 1980. Sixty percent of the increase in population is due to in migration, and that factor really indicates the new demands on the health care system in New Hampshire. I believe most of the people that are moving in from other places are of a higher income and demand more services. During the last 15 years, New Hampshire has had the largest percentage population increase of all the New England states. The largest growth is in the southern part of the state along the Massachusetts border and it's partially due to our 'no income' or sales tax situation in New Hampshire and the growth of the high tech industry. Growth is moving north and putting a great deal of pressure on our social service system. Although New Hampshire has the lowest unemployment rate in the country, that statistic is misleading. There are a number of different problems associated with low unemployment, especially concerning our teen population leaving school. Approximately 30% of high school kids don't graduate, partially due to the kids seeking "high paying jobs." Obviously, leaving school will limit their future. Short-term prosperity for them, will often result in a longer term burden for the state.

The three largest southern counties, Hillsboro, Merrimack, and Rockingham account for 60% of the state's population and that's all south of Concord.

Geography in New Hampshire is another critical element in the provision of services. There really isn't any major east-west highway that connects the state. Statewide, public transportation is a major problem, especially in the northern section of the state where the White Mountains create natural barriers for health services. We have to seriously consider transportation and geography as key factors in the provision of care. I briefly mentioned that there is no income or sales tax so we depend on what is called "sin taxes" which are taxes on beer, alcohol, and cigarettes as well as on tourism for most of our general funding base. A major factor affecting New Hampshire's delivery system is our very limited general fund money. Natality — In 1985, the birth rate of 15.4 is 1.9 below the U.S. rate but the difference is the lowest since the early 70's. Births to young women less than 20, continue to decline. Inadequate prenatal care has increased. Non-marital births have also increased. Again in 1985, we had 15,364 births of which a total of 1,269 were under 19 years of age. Low-birth weight babies totalled 751, for a rate of 4.8% which has been the same over the last 5 year period. Three hundred forty-eight women (2.3%) received late or no prenatal care. If you go one step further and look at the women who have started care late in the 2nd trimester, you open up another large population group that I would consider, high risk. This represents about 6,000 women. Two thousand forty-seven women (13.3% of all births) had babies out of wedlock. In 1985, there were 141 infant deaths for a rate of 9.8 per 1,000. The year before it was 10.2. Recently, I chaired and organized a task force that reviewed infant deaths in New Hampshire. We reviewed statistics in 1985 and the 10 previous years. We were able to use a birth-death link file to augment this report. In essence, the death rate has pretty much stabilized during this 10-year period instead of continuing downward as in some other states. I'd like to share with you the 5 specific factors identified by the Infant Mortality Task Force as related to this stagnation. 1) A halt in the declining percentage of very low-birth weight infants, 2) unchanging neonatal mortality among very low-birth weight infants, 3) an increase in post-neonatal mortality among infants of normal birth weight, 4) a large increase in deaths identified as caused by "other conditions originating in perinatal period," and 5) a failure to reduce the percentage of New Hampshire mothers receiving inadequate prenatal care since 1979. The recommendations that followed this report included: 1) An increase in statewide prenatal education (targeting teens, low-income families, women with less than 12 years of education, and providers of care), with a specific focus on smoking cessation during pregnancy, 2) improve statewide access to quality prenatal care (Hillsboro county should be targeted because it has exhibited the greatest increase in percent of women receiving inadequate prenatal care, 3) continued monitoring of adequacy of prenatal care levels and trends through our Vital Records office, 4) determination of barriers to prenatal care, 5) Medicaid reform to include an increase in the reimbursement rate for certified nurse midwives and physicians for obstetrical care and an increase in the income level related to client eligibility, 6) the establishment of two community-wide demonstration programs to strengthen families, 7) better access to quality child health services for poverty level families, 8) establishment of adolescent wellness clinics in the schools, and finally 9) increasing statewide access to family planning services. Some of these recommendations have been implemented and others we're still working on. From this report we had some very interesting spin-offs. Right now we are developing a committee to review each infant death. The focus of the committee will be one of education: for the general public, for those who are delivering care, and for policymakers at the state level. Another spin-off of the Task Force Report was the focus on Medicaid. Our reimbursement rate of 217 dollars for prenatal care is one of the lowest in the country. This has recently been increased to 460 dollars per client. This is still below many states but we're moving in the right direction. I know in Minnesota they had a crisis and called a special session of the legislature. They were reimbursing at 500 dollars per client, and increased their rate to 1,000 dollars.

Another positive outcome of that report, is the linkage between our Medicaid data and our birth and death certificate information. We can use this information to monitor access to care and its effectiveness in reducing low-weight births and infant mortality.

Bob asked me also to briefly mention some of the problems in New Hampshire as well as some of the successes and I'll start with the problems. Access to care is critical. I recently gave a presentation to the National Governors Association, and the problem of access is the same in all rural states. These include client knowledge of where to acquire the service, money to pay for the services, transportation to get to them, and the coordination between provider agencies which is probably the biggest problem. The supply of health providers is another critical problem. Right now we have trouble finding nurses and particularly nurse practitioners. We are also having trouble finding obstetricians. The liability issue is critical especially in working with our high risk clients. I think it's going to be a continuing problem unless they're linked up with a hospital to have that liability coverage paid for by a larger organization.

The HMO's I think have provided a nice source of health care for those who can pay. Those who can't pay, run into a problem. They often fall in the middle; not poor enough to get supportive assistance and not rich enough to pay the full fee. As the HMO's get stronger, hopefully, they'll be a bit more flexible about who they serve.

One of the things I've learned in my 13 years of work in public health, is that information is under utilized. There's a wealth of information in the State's Vital Records offices. However, information on injuries and teen health is not available. We know very little about our teens. We can't tell what specific problems there are with consistency from agency to agency, from program to program. For the teenage population in New Hampshire which is 20% of the state's population, there are very few integrated health programs. There are good individual programs in Mental Health, there are good programs in Alcohol and Drug Abuse, and in a number of other different areas but one of the things I see a real need for is the development of a concerted effort to address adolescent health needs as a whole. Funding is also a major problem. I think New Hampshire does well for what it gets in revenue. When I compare us with other states, such as Rhode Island, Massachusetts, and Connecticut, with larger budgets it amazes me that we do as well as we do. Our ability to do things is capped by limited federal funds and by our legislature, which has limited budget increases to 2 or 3% a year. That doesn't leave a lot of room to innovate or even provide many basic services.

I mentioned before a major problem is the inability to coordinate services of state agencies, county agencies, and non-profits in the community. The Bureau of Maternal and Child Health provides primarily family planning, child health, and prenatal care. Those are the three major program areas. We also have programs in injury prevention, lay midwifery, lead screening, preschool vision and hearing, perinatal, and adolescent health. We serve approximately 24,000 Family Planning clients through 11 agencies that we contract with. In child health, we provide services to about 8,000 clients through 26 non-profit agencies. We have 8 prenatal programs now, serving 1000 clients, and we'll have two more established by January 1st. The need, on the other hand, for all these programs, is for at least twice the number we currently serve. Some successes: In 1974, we had one prenatal program in Strafford County, with a budget of 100,000 dollars from the old maternal infant care federal grants. We split that money and diverted half of it, up north to Coos County because of a need for better prenatal care. At that point, Coos County had the worse infant mortality rate in the state. Today, they have the best, because we funded a prenatal program and combined it with family planning. We then added WIC and child health so that the services are really well coordinated there.

The other success story is this past year the legislature, after working with a coalition of agencies involved in family planning and prenatal care, authorized an additional half a million dollars to family planning and a quarter of a million dollars more for prenatal services. The quarter of a million dollars is starting up our two new prenatal programs this January and the 500,000 dollars allocated to F.P. will serve another 4,000 clients. The legislature was finally able to make a connection between prevention and a higher cost for a poor birth outcome. It took about 10 years of outside pressure to get this passed.

Finally, I see two major issues that I'd like to address during the course of this conference aside from supporting wholeheartedly what Bob is promoting. Listening to what Bob has been saying for the last couple of years, I have come to understand it better, but the two areas that I really see that are critical in terms of prevention are: adolescent health and men's health. Our country has yet to realize the health implications associated with our next generation. We need to start defining a holistic approach to this high risk group. In addition, we do not recognize the role that men play in the family environment. They're both a problem and a resource and until we recognize their role in the family, we'll never really deal with the problems of reproductive health, child abuse, injuries and all other health problems.

Report of the New Hampshire Delegation

2. Presentation by David Bundy

I represent the Children and Youth agency in New Hampshire, one of five divisions within the Dept. of Health and Human Services. We have been building over the last four years a comprehensive children's service agency. We are the agency that is responsible for child protective services in the state and do about 4,000 investigations per year. Sixty-five percent of the cases we substantiate involve situations where the abuser was a member of the household. We have a number of children in foster care. We have been trying to struggle with the whole issue of prevention in an environment where the basic services put us under a great deal of strain to just keep up, as some of the folks from Vermont were saying, with a very serious level of intervention. We have two other factors which I feel inhibit that. One, is our service delivery system in New Hampshire, from the Division's perspective, is tied to our juvenile statute and the bulk of our services are authorized by court orders, and you don't get before the court until your situation has deteriorated pretty badly. So most of our funding is tied around getting intervention to families after things have gotten so bad that it necessitates them getting before the district court. Essentially, we provide intervention and treatment to children in need of services, abused or neglected children and juvenile delinquents. The second dilemma that we have in the area of prevention, in doing a better job, is that the largest portion of our budget by far is court ordered services. We participate with county government in funding those services. The state pays 100% of services ordered by the district courts but receives 25% of that back through a reimbursement system from the counties which necessitates our tracking services by individual children. That puts us in a situation where we are unable to, without a great deal of difficulty, fund programs for larger populations because our reimbursement, 25% of our payment, comes back from the counties and you have to identify the children in order to bill back the counties to receive that 25%. Those are two significant obstacles for our doing more in the area of prevention. Overlaying that is the stress of the populations that we serve in an emerging system where we've done a great deal of reorganizing over the last four years moving large pieces of state government onto an umbrella agency and going through the normal anxiety that that creates with staff and the public. Despite that, however, we have been able to make some strides in the area of prevention and I'd like to make a few observations. We have tried to look at three areas: The first, is how can we better coordinate resources and have a multidisciplinary approach towards dealing with families. The second, is how can we move our system to focus more on the family unit rather than as seeing the children as a case and maybe the family as a case. And the third area is are there ways that we can open up our services to a broader population and intervene earlier?

In the first area, coordination of resources, we have been able to establish over the last number of years multidisciplinary teams in each of our twelve district offices where a network of providers from the community meet on a regular basis and assist us both with interventions of children and families who come into our system and also, at least in some areas, have moved to a point of discussing how can we hold services together and do a better job of intervention. We have also been able to impact at least to some degree through legislation, structuring better coordination, particularly between the Division and local education agencies and the Dept. of Education. We find a subpopulation of our clients who also have handicapped codes through the educational system. And the legislation in the last two sessions have mandated district court judges to enjoin school districts to discuss their individual education plans before the court with the Division so that we can better coordinate services for the child and the family.

We have tried to take some steps towards focusing the service delivery system on the family as opposed to the child. We have changed our definition of the case to be the family. Prior to that a worker would carry children in placement as individual cases and they would also carry the family as an individual case. We think that that's important to how they view the family, to see the family as a case even when the child is in placement, particularly where in most cases our goal is to reunify the family. New Hampshire has also seen over the last three or four years a rapid increase in what we call Family Strength programs, where private agencies are ordered by the court to do intensive case work models with the family. Workers have small case loads, 4 to 5 families at a given time and they're accessible 24 hours a day. They intervene and try and link families up with other services. The intent of the home builders, as this is known in other parts of the country, is to link families up to services, teach them how to navigate through the system of services, and get out within a short period of time, 3 to 6 months. The intent is to avoid placement by helping the family get at least to a level of functioning that makes it not necessary to remove the child from them. These services have grown over four years from a virtual zero base to an over two million dollar annual item in our budget.

The third is to fund, in a limited way, easier access to programs for a broader population and to intervene earlier. There have been three efforts in that area. The first, involving the largest amount of dollars, was part of a bill which changed how court ordered services were funded. There was a provision in legislation that 5% of the dollar spent on placement of children should be designated for placement prevention activities. That's a 700,000 dollar item this fiscal year in the Division's budget. What we have done is through a formula allocate that money to our county governments and while many counties have targeted the money for diversion or mediation programs, there have also been a number of efforts at early intervention and some more innovative projects. The second item is that our Division for Children & Youth Services by law has an advisory board of two people from each county and part of our mandate has been to try and take somewhat of a leadership role in a broader sense of promoting children's services beyond court ordered services. While we have been unable as yet as an agency to make significant strides, the advisory board has taken that as an area of interest and have designated 50,000 dollars annually of our juvenile justice funds on a competitive basis, to fund small prevention grants of from 500 to 5,000 dollars. The third area is that New Hampshire also has a Children's Trust Fund. As yet, it's been somewhat of a frustrating experience for those involved in it. There was no general fund appropriation but an escrow account of general funds which could be accessed dollar for dollar by funds raised in the private sector. The initial group of individuals on the advisory board, myself included, had very little experience in fund raising and the project was pretty well stagnated for a year. I think we're a little bit more optimistic now. We do have some dollars to fund private professionals to come and assist us with fund raising so we hope we will be able to leverage some of the state dollars that are in escrow.

I think it might be helpful just to mention a couple of the projects briefly and then a final comment about what I think is really lacking in New Hampshire to pull some of this together. From our preventive grants we have funded a community council for children's services in Newport, which is a moderately sized community, to do joint planning for services to children and they have succeeded in co-locating the Child Health Program, the WIC program, Headstart, and a day care program and they are trying to expand with some of the money to add additional services at the same location. We provide space for a children's center in Concord and we have funded a project called Child and Family Life Education Center in Laconia which is one of our cities in the central part of the state. It's a center where parents can drop in and talk with other parents and/or leave their children for short periods of time. They also volunteer to take care of other family's children.

What has been lacking, I think, is a perspective from the statewide level in terms of a commitment, a definition of what prevention is. One of the things that I found very interesting about Vermont, is at least through your legislation, you've identified prevention as a priority. There have been some attempts with the 10% allocation into prevention to structure how state agencies and other agencies in the system can approach prevention. I think that that is probably the most crucial thing that we need to see happen in this state. There needs to be, through the legislative process, an articulation of prevention as a top priority and to list some goals in areas and really put some structure to it. What we've been able to do and what other divisions have been able to do have been to focus on prevention from their own perspective in very different ways and I think we've done some good things, again as Charlie said, with a small amount of money. But there has been no structure pulling it together and I think at least in our state and I suspect with many others that needs to be the first step. Prior to coming to state service, I worked at the local level in the city of Manchester and attended a workshop a number of years ago which provided training in trying to get communities to focus away from children's problems or pathologies and talk about what would we like to have as the ideal young person coming out of the system. The term used was positive youth development. How do we as a community produce individuals who are happy and function well. You don't do that by saying, 'here's a problem, let's develop services around it.' You do that by articulating things that need to be present in a community for everybody so that the universal population can have access to it. We went through a planning process where we invited a number of people from the community in different sectors and identified five areas and tried to get the city to establish broad goals in each of those five areas. We looked at employment, family life, recreation, education, and social services and used that with the board, mayor, alderman, the school board, and United Way to help target how programs were funded and what interventions were done. We were able to see a very different level of program develop in certain areas. We began to do joint programming with Cooperative Extension. We saw the school board begin to do some family life curriculum. The process is one that needs to be really pushed and it needs to be done fairly frequently; getting the community back together to say let's reassess where we're going and to keep the momentum going. As often happens, those things tend to slow down and die out. But I think that that is the approach that's really necessary and one that needs to be translated to a state level. We've got to define in each area, in employment, in education what do we want to have happen to produce that positive youth development. This has not happened at the state level. If there is one thing that really needs to be done, I would say that that's what has got to happen first because otherwise we're just all going off in different directions and there isn't any central thread pulling it together.

Report of the New Hampshire Delegation

3. Presentation by M. Mary Mongan

My name is Mary Mongan and I'm the Commissioner from the Department of Health and Human Services in New Hampshire. I guess my presence here today, as one of those higher bureaucrats, is to try to listen and to understand and at the same time to try to manage the largest department in the State of New Hampshire. We have five divisions in that department and two other agencies. Therefore, I guess I must preface my remarks by stating that when I talk about healthy families, I mean more than the physical health because as commissioner of that department I have to take a look at the total picture and have a larger perspective and that's exactly what I try to do. Let me give you some remarks that I did try to put together thinking about what my presence was going to mean here today. In talking with Bob and with Charlie it was difficult for me to know. I wanted to come and listen to everything and I think it's been very good for me today, to hear the programs that are going on and try to measure where are we and I don't think we're that bad in New Hampshire at all. I think we do very well. We don't seem to have a lot of the dollars or many of the other things but one thing I continue to see within my department and continue to see in the community, is a good working relationship with the private sectors out there and with other groups who can try to fill in some of the gaps that we don't have the dollars to fill in for. Whether that's good or bad, I don't know but I think looking at it from my perspective it's good.

We have for too long treated individual and family problems in isolation from other disciplines. We assign people and their problems to categories and look for a single solution so we can fit a person into a program. For the department as a whole we counted the number of children we serve and it totalled about

400,000. For me that was interesting because we don't have 400,000 in the state, we have around 300,000 so I guess that says very clearly what we are doing. Many of the kids are receiving more than one service.

We are looking at community wide approaches when we count those for the health of the family. We looked at the schools, we looked at day care providers, the job training programs, the churches, volunteer groups, and to private and non-profit organizations. Employers have to have a major role to play in this entire effort based on the working hours that they provide or don't provide. Some of them provide health insurance and some of them don't, and some give you day care and some of them don't. If we are truly going to serve the young family, we must integrate and direct the services we provide. We must ensure that there is adequate health care but we also must realize that this is only the beginning. We must afford the young family the opportunity for a future complete with adequate income and housing as well as day care.

Let me describe to you an approach that we're taking from the department point of view. We are reforming welfare. All of you have heard about welfare reform and we do it a little bit different. We say we're reforming welfare and we're serious about it. We think our version represents a real change in the way we approach families in trouble. For a long time we were overwhelmed with eligibility, with error rates, with categorical approaches to problems, but our new program proposes a significant philosophical change. We want to promote a holistic approach to human beings; to families we want to help them deal with their problems not our definition of their problems. We want to promote self-respect, self-esteem, self-confidence, self-determination, and self-sufficiency. We want to prevent problems and dependency wherever possible and we will intervene early when we can and we will provide supportive services designed to eventually achieve independence. Our AFDC case role in New Hampshire right now is about 3,700. In the past 3 and 1/2 years, we have dropped from 8,400 down to about 3,700. So this welfare reform or reforming welfare has begun within our system and with our own staff really taking a look at how can we do some positive things to work with our families as a whole. We haven't waited for the feds to come by and say 'why don't you take a look at it.' The program that we're developing will focus on developing a contract between the case manager and the client. The contract will include the responsibilities of the state and the responsibilities of the client, individual or family. The state case manager will package all necessary services that will provide needed assistance and that will promote and encourage the well being of that young family. We will develop a full-service plan for our Human Services District offices where they will be working through. We will meet the needs through the traditional mechanism which is AFDC, food stamps, and Medicaid when necessary. In addition, we will refer our clients when necessary to family planning, to the WIC program, child health clinics, job training, education, counselling, and any support services within local community resources that the individual family needs making sure that the network out there is available and that we are making the best use of it possible. The accent must be on the individual family. There is not a single answer for all families and, if we are to be successful, we must listen better. Listen to their problems and their barriers and their needs. If we listen and together design individual solutions for individual families, we will be far more effective in helping those families succeed and become self-sufficient. What better gift could we give a child than to help build an environment where parents are economically independent, where parents are accessing care for their children and themselves, where there is an ability to cope with problems and find solutions, and where family members see each other as resources and where we try to give them hope. It is critical that we each continue to expand knowledge within our own disciplines and that we share that knowledge as we are doing today. This is certainly most helpful to all of us who shape and implement policy and that's what most of you are doing. But each juncture is just as important and we urge the integration of policy. It is a cross discipline approach in an integrated service system that I believe holds out the most promise to developing young families.

When the paper memo came down to me, it said Mary Mongan will present her perspective on the overall needs of the families and how she determines how she tells the governor to prioritize his funding. Mary Jane Wallner, who is one of our legislators said she came today just to hear me answer that. I'm not going to answer it though. No, actually prioritizing is something that is done in every agency that you work in. We're no different. We're a very large department and as a large department, when we develop the budget, we did prioritizing and each division director came in with their priorities and we took a look at those priorities and they had a lot of input into them. So when decisions were made, it was not made completely at the commissioner's level. For a commissioner to do that or for any executive to do that would be wrong, so it comes from each person having their input. And it's tough. To do prioritizing is tough, just as it is in the legislature. But we try to do the best we possibly can and this past year we brought in a budget that was completely in the black for the first time in quite some time in the history of the department and I feel good about that. So my role here today, and I appreciate being able to come for the short time that I can stay, is to try to get out and to see what's going on and to listen to other people and moreover to support my department and my division directors and division staff in any effort that they do and we certainly appreciate Bob's role not only of our division but with the Dartmouth Clinic and I think that's an important piece for the department, so that's my role.

Report of the New Hampshire Delegation

4. Presentation by Mary Jane Wallner

I'm Mary Jane Wallner and I am a state representative for the Concord area. I thought I would tell you a little bit about the New Hampshire legislature because I think it makes a lot of difference in terms of what happens in New Hampshire. There are 400 state representatives and 24 senators. Now you can get a flavor for what some of New Hampshire's problems may be. The average age of a legislator in New Hampshire is 59 years old, so the legislature is made up of a large number of retired people who have the time to devote to this and come at it from a bit different perspective than some of the more professional legislators in other states. The turnover rate in the legislature is about 40% every two years, so these folks in state government have to be reeducated every two years. A couple of years ago I got involved in a bill called the Children's Trust Fund and because of that bill I learned about what level of understanding people in the New Hampshire legislature really have of the concept of primary prevention. Our bill looks a lot like other states' children's trust fund bills in that it's really geared towards funding primary prevention programs. But when we arrived at the New Hampshire legislature with that bill, there was a lack of understanding of what we were talking about—what are primary prevention programs, who will they serve—and when you start talking about they're going to serve the entire community, they're going to be available for anyone, this was something that was very difficult for them to understand. That whole situation around our Children's Trust Fund was a very frustrating experience. Even though we do now, in legislation have a children's trust fund we actually have no money. What the legislature did was tell us that if we could raise money, they will match it. What they gave us was a million dollars which is being held in escrow and if we can raise a million, then we would have a two million dollar trust fund and we could spend the interest from that money for prevention programs. That could be a significant program if we can raise the million dollars. They left us out there, a bunch of volunteers basically, to raise a million dollars. David and I were two of those volunteers faced with this problem which for a year we tried to cope with and finally realized that we weren't going to be able to do that. We went back to the legislature last year and asked them to give us some resources to raise that million dollars. They gave us 90,000 dollars to go out and hire the kind of consultation that we were going to need to raise the money and we're in the process of doing that now. And I hope that once we raise the million dollars, New Hampshire will have made a significant step in funding some prevention programs.

In my other life, because in New Hampshire if you're under the age of 65 and you haven't retired yet or you're not independently wealthy you also have to have a full-time job. I am also the director of a day care center. I noticed we were lacking in the New Hampshire presentation of what some of the day care statistics are. As you heard, we have the lowest unemployment rate in the nation and we also have a heavy emphasis on welfare reform, and as Commissioner Mongan told you, we have very few welfare cases left. Everyone's working in New Hampshire and, as you're driving around, everybody needs workers—McDonald's and Wendy's. There's a job out there for almost anyone who wants to go and look for one. So we have a very high employment rate of mothers in the work force. Right now we have about 35,000 preschoolers and about 70,000 children of school age who for some part of every day need child care. At this point we have 1,000 licensed child care providers and they provide 22,000 slots for child care a day in New Hampshire so we have quite a gap. We have 105,000 children who need child care and we only have 22,000 slots so a lot of those children are in unlicensed care. Some of that is not illegal care because in New Hampshire you only need to be licensed if you take 3 or more children. I think that that is one place there have been some small successes in the New Hampshire legislature. Last year we did have an influx of money into the system for low and moderate income working families. There's about 2.7 million additional dollars that is going to go into the child care system in the next couple of years. We do fund child care for families who make up to 190% of the poverty level which is not as good as Maine but some of the child care advocates are really working, to get those income levels looked at.

At the federal level, there's something called an 'Act for Better Child Care' and there are about 50 organizations nationally that have gotten together to support it. The Children's Defense Fund has really spear headed this and a bill is going to be introduced in Congress for about 2.5 billion dollars of child care money across the United States. For New Hampshire that would mean about 5 million dollars, so you can take that for your state and try to figure out what it would mean. Seventy-five percent of each state's money would need to be used to provide direct care for children, but 25% of it would be to upgrade the care given to children through training of providers and through licensing requirements. One way to go about passing this legislation is to try and develop state coalitions. These are being organized in every state in the United States. A couple of weeks ago there was an organizing meeting in New Hampshire which pulled together child care people from all over the state. We in New Hampshire do not have a children's forum or a coalition for children and this might be the beginning of that because we need that not only for this federal legislation but we also need it for working through the state legislature.

I'm really glad to be here today because I am going to be sponsoring, in January, a piece of legislation that would provide the first state dollars for Headstart in New Hampshire. We're asking for half a million dollars to expand the Headstart services so I feel this is going to be valuable for me to learn today more about Headstart and to use the information in helping pass our legislation.

(*Berry*) I had a question about your AFDC case load. What is the reason that it's going down?

(*Mongan*) Well, the healthy economy of the state certainly and the employment's out there. The other thing I think is what we have done in our district offices, the case management, which I talked about, whereby when a client comes in they just don't say, "You're on AFDC," they say, "What's your education? How can we get you into a job training program?" These are some of the things that are more positive. That's why I said in the beginning we would talk about welfare reform. We've been reforming welfare, and I think have done a good job.

(*Berry*) Is your eligibility rate the same as Maine or Vermont? It's lower isn't it?

(*Mongan*) It varies. It's 69% of the Federal Poverty Level for a family of two, 63% for a family of three, and 58% for a family of four.

(*Berry*) Has your eligibility gone down over the second term?

(*Mongan*) No, it has not. It's the same.

(*Sgambati*) What's yours in terms of the percent of poverty?

(*Berry*) I think it's 115-117% of the Federal Poverty Level.

(*Mitchell*) Are your families able to stay on Medicaid when the mother starts to work?

(*Mongan*) We have just instituted a program whereby we're beginning to allow that to happen. That was one of our biggest problems that we've had. But we now have a program where we're doing it for six months and hope to increase that to a year.

(*Chamberlin*) The problem with a full employment is that people are making $5.00 an hour and rents have gone sky high so they're paying 50% of their income for housing.

(*Sgambati*) There's been both positive and negative sides of the full employment or near full employment. One of the positive things is that the employers, in order to be competitive, are now offering medical insurance at a fairly decent coverage which was not the case in the past. So that's been important for that group of people. We're looking at extending Medicaid and also maybe buying for some of those people the additional coverage above and beyond the employer's coverage so we can get family coverage instead of just the employee.

(*Mitchell*) Say somebody starts working at McDonald's and they are now providing individual coverage, if they would have been eligible for Medicaid, can you instead of providing Medicaid, buy the family insurance?

(*Mongan*) You are able to do that depending on what the need is. We have a waiver from the federal government to allow us to do that.

(*Sgambati*) What we've done currently is extend Medicaid coverage for up to between 9 and 12 months depending on the income level but what happens is we will bill that insurance if the person is covered there. Medicaid is the payer of last resort in the scheme, so when the bills get submitted and somebody is covered by insurance, that's picked up by the insurance. If there's other things their's don't cover, then Medicaid will pick that up.

(*Mongan*) We've done that with our Catastrophic Illness. We don't have a Catastrophic Fund per se but we have taken care of it whereby we're the payer of last resort.

(*Mitchell*) Do you cover prenatal care then for uninsured people the same way?

(*Mongan*) No.

A Community Based Approach to Preventing Heart Disease: the Stanford Experience

Christine Jackson, Ph.D.

(*Chamberlin*) We will now begin to look at other programs around the country that have had experience in implementing community wide approaches. The first one is the Stanford Heart Disease Prevention Program which has had a community wide approach to changing health habits related to cardiovascular disease. Presenting that is Christine Jackson who is Associate Director of Education at the Stanford Center for Research in Disease Prevention. She is responsible for designing and implementing risk reduction programs in communities and for conducting the evaluation necessary to determine the extent to which the programs are maintained by the community and the association between program participation and improvement in risk related behaviors. Dr. Jackson has a Ph.D. in Social Ecology and wrote her thesis on the effects of health related knowledge attitudes, beliefs and situational factors on heart health behaviors in adults.

(*Jackson*) I'd like to begin telling you a little bit more about the Center for Research in Disease Prevention, both to clarify some of the terms that I'll be using today and to convey to you the timeliness of our current efforts within the Center and this conference's focus on applications of community-based programs to maternal/child health issues.

STANFORD CENTER FOR RESEARCH IN DISEASE PREVENTION – PROJECTS:

Heart Disease Prevention Program (Five City Project)

* A community demonstration trial
* Based in five cities in northern California
* Funded by National Heart, Lung & Blood Institute
* 1978-1991

Health Promotion Resource Center:

* One of four regional centers established to serve as a resource for community-based health promotion in the United States

- Region includes the 13 western states
- Funded by H.J. Kaiser Family Foundation
- 1986-1990

The name of our entire organization within the university is the Stanford Center for Research in Disease Prevention. There are currently about 20 projects within the Center. The two projects of interest to us are:

1st: The Heart Disease Prevention Program (HDPP), which is also known as the Five City Project (FCP) and has, since 1978, been the largest project within the Center.

2nd: The Health Promotion Resource Center (HPRC), which is the most recent large scale project to come to the Center and which in many respects represents the next generation of community programs attempted by our group.

The HPRC works with 11 funded communities in the 13 Western United States. These communities are dealing with not just cardiovascular disease, but adolescent pregnancy, substance abuse, cancer and injury prevention.

I mention the HPRC now to let you know that (1) the generalizability or applicability of our experience in the FCP to other communities and other health problems is currently a principal area of interest within the Center, and (2) while most of what I have to say about the "Stanford experience" is based on the Heart Disease Prevention Program in Salinas and Monterey, I will also be taking into account the Center's ongoing efforts to assist the 11 funded communities in their health promotion efforts.

As I started to prepare my talk, the first thing that came to mind is that I've been immersed in cardiovascular health for the last few years and in any case know very little about maternal child health. So, I thought it best to do some background reading and turned to the materials forwarded by Dr. Chamberlin. As I read through the titles in the bibliography and looked through the other materials, I immediately noticed several titles that contain the same word, namely, "ecologic."

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Child Maltreatment: An Ecological Integration

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Other references to the ecological model:

"The Ounce uses an ecological model in implementing prevention services."

Gershenson, H.P., & Musick, J.S.

"The models underlying the intervention efforts of the '60s and '70s were much too simplistic. The family resource movement takes the real complexities of life in our society as a given. The family is viewed as a complex dynamic system which itself sits at the intersect of, and is influenced by, other complex systems such as the human services system, the health system, the school, the media, the workplace and government at every level."

Zigler, E.

Probably one reason that I gave special attention to the repeated use of the word ecologic is that I did my graduate work in Social Ecology at the University of California. More importantly, however, is that a principal characteristic of the Five City Project (FCP) is that it was planned, implemented and evaluated as an ecological intervention. To discover what about the FCP is applicable to other communities, and to other health problems, we need first and foremost to understand its ecologic structure and processes.

With that in mind, I'd like to introduce you to the FCP by first giving a brief answer to the question: What is an ecologic orientation?

AN ECOLOGICAL APPROACH TO HEALTH PROMOTION ASSUMES THAT:

1. HEALTH RELATED BEHAVIOR DOES NOT OCCUR INDEPENDENT OF THE INFLUENCES OF THE SURROUNDING PHYSICAL AND SOCIAL ENVIRONMENT.
   - Much of the program planning work of the Five City Project involves understanding the nature of people's interactions with the surrounding physical and social environment.
2. A COMMUNITY IS A DYNAMIC, INTERDEPENDENT SYSTEM CHARACTERIZED BY NORMS, RULES AND ESTABLISHED METHODS OF RESOURCE ALLOCATION.
   - Much of the community organization work of the Five City Project involves learning how various parts of the community system function, and collaborating with representatives from the system so that they will be receptive to and supportive of health promotion activities.

To keep things simple, I will focus on the two basic assumptions of an ecologic approach:

1. The first assumption is that human behavior does not occur independent of the influences of the surrounding environment.

   Interventions based on the ecologic model takes into account the context in which behavior occurs.

   This model acknowledges that there are some innate or genetic characteristics that may predispose and in some cases, cause, an individual to behave in a certain manner or develop a certain health problem.

   However, this model emphasizes the relationships between the physical and social environment, individual behaviors and, physical and mental well being.

   When viewed from this orientation, a health promotion program is an attempt to influence individual behavior through changes in the surrounding physical and social environment.

   Much of the *program planning work* of the FCP involves understanding the nature of people's interactions with the surrounding physical and social environment.

2. An ecological orientation is also a systems orientation. That

is, it takes into account the dynamic and interdependent nature of human communities.

It recognizes that human social systems are characterized by certain norms and rules and that they generally contain a stable amount of resources.

Accordingly, when a health promotion program is implemented, it is essentially a disturbance within the system. It is a disturbance in the sense that it seeks to *change* the status quo, *reallocate* resources, alter some of the existing norms and so forth.

Much of the community organization work of the FCP involves:
- learning how various parts of the community system function and
- collaborating with representatives of the system so that they will be receptive to and supportive of our health promotion efforts.

To summarize: at a general, conceptual level, the FCP is ecological.

The intervention has taken into account *environmental* as well as *individual* factors that influence the rate of cardiovascular disease.

Program staff recognize that the intervention in essentially a pertubation within the community system and that considerable work is required to see that the system accommodates the intervention.

Now I'd like to move to a more detailed look at the intervention, and provide an overview of the program activities that have occurred during the course of the Heart Disease Prevention Program.

I've brought along a video, called Community Health Promotion that has just been produced by our group, that I think provides a good overview of the program (video shown).

What I'd like to do now is to briefly *summarize the key components* of the FCP intervention. To do this I have prepared a graphic that uses a very simple ecologic framework as a tool for organizing the program activity information presented in the video.

Stanford Model for Developing Overall Community-Wide Framework for Preventing Cardio-Vascular Disease

COMMUNITY HEALTH EDUCATION PROGRAM ➨	FACTORS THAT INFLUENCE INDIVIDUAL RISK OF DISEASE ➨	RATES OF CORONARY DISEASE
Social Level Variables: - parental behaviors especially for diet, weight, exercise & smoking - peer pressures - social & cultural norms & traditions Organizational Level Variables - school health curricula - restaurant & grocery store labeling - worksite facilities, policies & programs - physician practices - screening programs for blood pressure & cholesterol - hospital prevention programs - public health information programs Community Level Variables - mass media for health education - commercial advertisements - labeling laws for foods & cigarettes - societal trends for smoking, exercise & diet	Awareness and Knowledge about: - cardiovascular risk factors - actions to reduce risk status - community resources to learn health promotion activities Attitudes and Beliefs about: - one's probability of developing heart disease - the usefulness & desirability of following preventive actions - one's likelihood of success in following recommended actions Skills: - label reading - resisting peer pressure - avoid smoking relapse - initiate an exercise or weight loss program - comply with medical regimen Behaviors: - diet and nutrition - physical activity - cigarette smoking - weight control activities - use of hypertensive meds Demographics: - socioeconomic status - age - gender - family history - ethnicity	Chronic Disease - angina pectoris - myocardial infarction Premature Death - mycardial infarction - stroke

Four key components of the program are suggested by this graphic:

1st: When considered as a *whole* the model depicts the *comprehensive* nature of the intervention. It is comprehensive because it targets multiple risk factors with programs and products that involve multiple community settings, change strategies and target groups.

The *working assumption* of the program is that the more the education program becomes an integral part of the surrounding environment, the greater the individual exposure to the intervention, the greater the reduction in risk-related behaviors, and the greater the decline in CVD rates.

2nd: The box on the left suggests that the intervention is essentially designed to *alter the environment* so that members of the community are provided with *multiple and variable opportunities* to modify their risk related behaviors and thereby lower their risk of disease. In this model, environmental factors are sorted along a simple micro to macro level hierarchy.

In general, micro level variables are characterized as being proximal to individuals and present on a more or less continuous basis. Things present in people's immediate social environment, such as family tradition, parental modeling, and peer values, are micro level variables.

Beyond the immediate social environment are the organizations that comprise the broader community environment; the schools, churches, hospitals, businesses and other organizations in the community. The regular activities and special events that occur in these places are what make up the community environment. Because different segments of the population come in contact with different combinations of organizations, the "mix" of organizations targeted by the intervention has implications for who will be exposed to the intervention and to what degree.

Within this framework, macro level variables are variables that generally influence the community at large, are often regulatory in nature, and often have a range of influence that extends beyond the community. Examples of macro levels variables include mass media and food and cigarette labeling laws.

During the course of the intervention, educational programs have been directed at the various levels of this hierarchy.

3rd: As depicted in the center box in the model, the intervention has targeted psychological and behavioral aspects of risk factor modification. Although there is some debate about

> whether change in knowledge and attitudes must occur in order for behavior change to occur, the general orientation within the Center is that under most circumstances, modification of psychological variables and the acquisition of necessary skills will facilitate the performance of new behaviors.

This is not to say that all of our programs or materials are designed to modify all of these factors. In fact, we try to *limit the change objectives* of a single PSA or booklet or other health promotion tool so that we deliver a concentrated, focused message about a specific change objective rather than a diluted, complicated message about multiple change objectives.

It is by producing a *variety* of materials and programs, which may, for example, be purely motivational, be primarily educational or be focused on skill development that we hope to achieve a good fit between what we're sending out into the community and the receptivity of persons in the community.

Finally, two other characteristics of the project, not directly apparent from this graphic, are that it is multidisciplinary and collaborative. The range of skills needed for the program is very broad. For a single program we may require people who can edit film, do blood draws, direct a community advisory board, design an evaluation, and so forth. The work that we do simply couldn't progress without the input from the multiple disciplines and professions represented on our team.

Collaboration is important, but also expected, among our staff. Where collaboration is more unique, and difficult to achieve, is between the project staff and members of the community.

Now that you have a general sense of *what* we've been doing, I'd like to shift gears and describe *how* we go about doing it and I'll do that by describing our planning and implementation process.

First, a general word about the nature of planning and implementation of any aspect of the HDPP: I think Richard Manoff's description of the communication process is an apt description of how we operate. In his book on social marketing, Manoff states that Paths become clear once the directions are taken. For us, program planning and implementation is a very dynamic process. It starts with an idea and that idea is usually shaped and reshaped many times as information continues to come in regarding the target audience, the setting, potential barriers for use, and other kinds of information that I'll discuss in more detail in a minute.

The point is that we don't take an idea and develop it in isolation within the university. Throughout the process our *work is* *guided* by the information we collect from individuals and organizations in the community.

As much as it is a dynamic process, there are elements of the process that remain constant and I'll describe these elements next.

A PROCESS FOR PLANNING AND IMPLEMENTING HEALTH PROMOTION ACTIVITIES

PHASE I	PHASE II	PHASE III	PHASE IV
NEEDS ASSESSMENT →	FORMATIVE WORK →	PRODUCTION & TESTING →	IMPLEMENTATION

The first constant is the general sequence of events, which I've shown as four phases . . .

I Needs Assessment
II Formative Work
III Production & Testing
IV Implementation

There's really nothing terribly innovative or unusual about this sequence. We identify a need, come up with some ideas for addressing the need, develop a prototype based on our ideas, see how well it works, fine tune it and then go with it.

What is somewhat more unusual, especially within the public health sector, and what is certainly the most challenging aspect of the process, is the range and amount of information we gather to guide our work. If you think about the entire process as essentially being one of gathering and applying information, then the challenge is knowing what kind of information to gather, how to gather it, and how to apply it.

For us, meeting this challenge requires us to (1) have a decent understanding of empirical research and social science theory, (2) to conduct ongoing evaluation using quantitative and qualitative methods, and (3) to conduct ongoing community organization work.

For empirical and theoretical information we turn to epidemiology, biomedical research, and the literatures on social learning theory, communication and persuasion and social marketing.

Our principal methods of evaluation are face to face and telephone interviews, self-report questionnaires, focus groups, observational study and physiological assessment.

Our principal methods of community organization work are community coalition building and consensus development. We reach the community through a 14 member community advisory board and its executive director (who is also our community coordinator).

These are the activities that provide us with the information we need to put together a health promotion program or product.

Next, I'd like to discuss in more detail *each phase* of the planning and implementation process and while doing so provide examples of how our use of theory, evaluation and community organization is central to what we do.

PHASE I

A very practical definition of needs assessment is that it tries to assess the *difference* between where the target population stands with respect to some health related outcome, and where you'd like them to be. The discrepancy between where they are and where they could be — that is, the assessed need — forms the basis for specifying the program goals, which are the end products of the needs assessment phase.

During needs assessment, we utilize theoretical and empirical information to better understand the problem, and the options for doing something about it.

With regard to cigarette smoking for example, epidemiologic data inform us that: while overall smoking rates have declined, they have declined more among males than females; that the slower decrease among females is due to the higher rate of smoking adoption among adolescent females, and that adults who continue to smoke are for the most part heavy smokers, who apparently are much less receptive to the smoking cessation programs currently available. We find this sort of epidemiologic data very useful in our efforts to identify health promotion needs in the community.

As a second example, we stay abreast of the everchanging biomedical information regarding the role of cholesterol as a cardiovascular risk factor. In order to establish goals for a cholesterol lowering campaign, for example, we would need to know what constitutes a meaningful drop in cholesterol levels, how long it would take to lower ones cholesterol by that amount, whether the new finger stick method of cholesterol measurement is something we want to encourage our communities to do, and so forth.

We also rely very heavily on our project's internal evaluation system to inform us about the health education needs of the community. We use data from telephone interviews, face-to-face interviews, physiological assessments, self-report surveys and observational study to provide us with indications of the community status with regard to:

— the availability of health promotion activities,

- the extent to which people in the community participate in health promotion activities,
- the risk factor status of people in the community,
- and the CVD morbidity and mortality rates in the community.

Community Organization work also plays a role during the needs assessment phase. To explain our community organization work, I should first describe the structure of our group. Part of my role is to serve as principal liaison between the Center and the community. The Center supports two full-time employees who live in the community and work as our community coordinators. One of these persons fills the role of executive director of our community advisory board. We have a 14 member board which includes physicians, lawyers, bankers, real estate developers, educators, a politician, a hospital administrator, a health department director and community service agency representatives.

Our goal in putting the board together was to pull together the decision makers or power brokers in the community In order to get into community systems, such as the education system, or work directly with the Health Department, we needed influential local persons to help us establish contact. We thought that would be sufficient. In fact, we're now modifying our approach so that we're evolving into a two-tiered system that includes power brokers who help us gain entry into the system and then another group of management level people, such as program directors, to help us set directions and specify goals and objectives.

(*Chamberlin*) How do you identify the power brokers in a community?

(*Jackson*) We relied mainly on our knowledge of the community and informational interviews of members of agencies and institutions in the community. If you look a the last names of the people on our board and then drive around the community, it's their names that are on all the buildings. Its common knowledge really. We did interview physicians and other people in the community and they were able to advise us and introduce us to others in the community network.

When a need becomes apparent, whether through our reading of the literature, our evaluation work, or because it is brought to our attention by individuals or groups in the community, we take our needs assessment information before the board. We work with the board not only to get their approval, but also because they can give valuable advise on how to proceed, and when necessary, they can open most of the doors that we may need to get through.

One of the first lessons I had to learn in my role was that I couldn't come to the board and define a problem. I think its very important to let them define the problem and get a sense of ownership about the problem. Our general approach is to present them with needs assessment information and see whether they think it's a problem. I think this is a really important aspect of collaboration with the board.

One of the difficult and time consuming aspects of working directly with the community to identify needs and establish goals is that we very often get caught in a mix of perceived needs as well as actual needs and political and economic needs as well as health needs. For example, often a single health promotion activity can serve a variety of needs. We are currently co-sponsoring a cholesterol screening program and the local hospitals are really involved to strengthen their position in the market and to compete with one another; television stations are involved to improve their public relations; the Heart Association and Red Cross are involved because it fits within their mandate and because they compete with one another; the Medical Society is involved because it seems that physicians are concerned about the introduction of a cholesterol screening program into the community without it being under their control. On the surface it looks great — all these organizations cooperating to do cholesterol screening; everybody is involved. We really are all moving in the same direction but there are definitely multiple agendas. It is undoubtedly rare not to have to deal with such mixed agendas. It may be worthwhile to accommodate needs not central to the program's mandate if doing so is likely to improve the community's receptivity to and/or ownership of the actual program.

PHASE II

Once we've established the need, we then try to figure out exactly what to do about it. During Phase II we formulate a plan for closing the gap between where people are and where they could be with respect to heart disease prevention. Thus, during the Formative phase we develop a plan that specifies:

- who the target audience is,
- how we're going to reach them,
- what information or activities we'll expose them to,
- how often and in what settings we will reach them.

To develop such a specific plan we lean pretty heavily on the social science literatures, most notably the literatures on Communication & Persuasion, Social Marketing and Social Learning Theory. These literatures are particularly helpful because they describe the variables that ought to be taken into account when attempting to bring about change in human behavior.

Social marketing, for example, emphasizes that in order to develop feasible program objectives and maximize the probability of reaching those objectives, we must first and foremost know our audience or target group. The goal is to develop a program or product that appeals to and is likely to be used by members of the target group. Thus, the purpose of target group analysis is to uncover the logistical, socio-cultural, psychological and behavioral factors that are likely to enhance or inhibit involvement in your program or use of your product.

At a practical level, what social marketing encourages us to do is put ourselves into the social situation and mindset of the members of the target group. The social marketing ideal is to learn enough about the expectations, desires, general lifestyle and situational characteristics of the target group that one can accurately predict how they will respond to the program or product in question. You really need to have as much information as you can because once your programs or products are out there, you can change some things but you really can't change too much.

As an example, we recently had the opportunity to examine the feasibility of "repackaging" a church-based family health promotion program. This program had been successfully implemented with Anglo families and we thought it may be transferrable to the Hispanic community. Through interviews with Hispanics we identified several critical barriers: (1) Hispanic men traditionally do not get involved in matters of the household, including nutrition and childrearing. Thus, we could not expect the program to appeal to entire families, as we'd hoped. (2) Because of their expressed desire to become more liberated in general and to use birth control in particular, some Hispanic women were not comfortable with the notion of a church-based program. Such a program would bring health and religious interests together at a time when women were trying to keep them as separate issues in their lives. (3) We learned that we could not expect to hold regularly scheduled meetings and that the overall time frame of any program would have to take into account the migration patterns of Hispanics who follow the growing seasons of the California agriculture industry. This example underscores the importance of knowing the cultural, psychosocial and logistical aspects of the target group.

During the formative phase we also utilize Social Learning Theory. Much of the structure that goes into our classes and self-help print materials is based on Social Learning Theory. This theory suggests, for example, that the adoption of new behaviors is more likely to occur when (1) individuals set several small goals rather than fewer large goals; (2) when they have the opportunity to observe others perform the behavior; (3) when they are given repeated opportunities to practice the new behavior, and (4), when they are given feedback on their performance. These are the sort of behavior change principles that we try to build into a printed booklet, a self-help kit, a health promotion class, and other health promotion activities.

Our evaluation efforts during the formative phase take on a more qualitative nature — we use focus groups, and personal interviews as tools for learning about our audience and testing our concept and design. At this point, our Community organization work is very closely connected to our evaluation work. We work with board members to gain access to potential target audiences so that we can learn about them and test their responses to our program and product ideas. Recently, for example, we wanted to develop a physician education program and through our board members we were able to meet with the Medical Society to get their feedback on our idea. We discussed what kind of information they want, what format they want it in, how much they want, and so forth. A lot of convenience issues and logistical issues about reaching physicians became apparent as a result of this effort. Similarly, over the last few months we have been meeting with pharmacists in the community to discuss an idea that involves the sale of health promotion materials by pharmacists.

Our community organization work is also guided by social marketing concepts. We examine other agencies and organizations to find out whether they have or are planning to offer similar health promotion activities. Almost always, we will not compete with those groups by designing a "bigger and better" program, but will instead try to collaborate with them to improve the quality of their program. We take this approach to avoid generating any resentment by these groups, to stick with our commitment to work within the community system, and to take advantage of the opportunity to reinforce what is already an *institutionalized* program.

By the end of the formative phase, we have acquired a detailed understanding of who our target group is and we have used that understanding to specify what we want to do as well as when, where, and how we want to do it.

PHASE III

As we enter the production phase, our job is to translate our program objectives into product design. The product to be designed may be a course curriculum, booklet, screening protocol, role-play vignette, television spot, radio program, menu label, and so on. Our job is to decide on the characterisitcs of these products, including their content, length, tone, color, size, shape, and texture.

The production phase involves and interesting blend of technical skills, creativity and applied social science. The process usually begins with the social science and community organization staff conveying the program goals and objectives to the writers, designers and/or broadcast media producers. We meet many times — until the health promotion message is clear and there is general agreement on product characteristics. From there, the people who actually do the writing and design work pass successive drafts of their work by the technical staff, who keep cost and production time in check; by the social science staff, who evaluate how well the work incorporates behavior change principles such as the four Social Learning principles mentioned previously, and by the medical staff, who verify the accuracy of any health and medical information.

Eventually, we have a product we can pretest. Through focus groups, interviews and surveys, we pretest for readability, comprehension, interpretation and reaction. We than make modifications as necessary until we have a prototype. For some products we conduct a field test. Usually this is done for products like curricula or courses, where successful implementation involves more than simple distribution, but instead involves correct use of the product by members of the community (e.g., teachers, physicians).

For the actual mass production of products we do contract with outside vendors. The challenge at this point is of course getting everything finished on time. One of the least generalizable aspects of the Five City Project is the production quality of our materials. By production quality I'm referring to factors like the weight of the paper, whether its gloss paper or not, the number of colors of ink used, and so forth. The cost associated with high production quality is substantial and most communities cannot afford to pay what we pay for health promotion materials. We are working to modify them so that they can be reproduced at a lower cost. Some members of our production staff feel that this will reduce the effectiveness of the materials. For example, one of the production decisions that was made for part of a cholesterol lowering self-help kit called "Eat Right" was to color code various sections so that people could more easily pace themselves through the program. If you pull the colors to save money, it may reduce the likelihood that people will complete the program.

Community organization does not play a major role during production, although we do rely on our community coordinator to arrange pretests and field tests. Because implementation is just around the corner, our community organization efforts during Phase III involve keeping the board and other community groups informed of our progress, recruiting volunteers, scheduling training sessions, soliciting free air time from media stations, writing press releases, getting co-sponsors, and so forth. In brief, we rely mainly on the community staff to handle the logistics of program implementation.

PHASE IV

Implementation is clearly the most practical phase of the process. With the community's help we coordinate project elements like training sessions, materials distribution and followup. In many respects, this is the community organization phase because all activities occur in the community under the supervision of community members.

The implementation phase also has a strong evaluation component. As much as possible we conduct process and outcome evaluation. Our process evaluation is intended to document the occurrence of program activities and to monitor program events. If things don't proceed according to plan, we're likely to learn about the problems and so have the chance to make changes because of the process evaluation.

Because the Five City Project is also a research project, the same instruments that help us identify program needs also evaluate program impact. With each repeated measurement, the research surveys indicate whether the community is essentially less in need relative to its standing on the previous set of measurements.

The length of time it takes to run through the entire planning and implementation process of course varies from project to project, but a typical run for the Five City Project would be about nine months, with six months of planning and three months of implementation.

Summary

When one considers the ecological framework of the Five City Project, it is apparent that the project has a complex structure. And when one considers the planning and implementation tasks just described, with its underlying emphasis on theory, evaluation and community organization, it is apparent that the project involves complex intervention processes. It is the attempt of the

Five City Project to match its program efforts to the complexity of the problem that may be its major contribution to the health promotion efforts of other communities. I think it is important that during our planning efforts at this conference, we not shy away from this degree of complexity when thinking of new options for maternal/child health programs.

Question: With regard to the sample materials that we saw, it seems as if each is specifically developed for the community that you'll be using them in or can some of them be used in other settings as well?

(*Jackson*) We now sell materials through the Health Promotion Resource Center. They have what they call a distribution clearinghouse and what they are doing is taking a number of print materials like Eat Right, a cookbook, the Nutrition Kit, and so forth, and repackaging them for mass distribution. Sometimes we sell a phenomenal amount; a state may call and want to buy 100,000 of something; other sales are for 2 or 3 pieces. Because we're a research center and a non-profit organization, dealing with copyright issues and distribution and sales issues is a new experience for us. Quality control and protection of copyright are challenging. We are accountable to the Office of Technology and License within the University and learning all the rules has been difficult, but we're working on it.

(*Chamberlin*) One of the ways to implement this in local communities from a state office would be to get the local community to form a board and them provide them with technical assistance in the form of a person with social marketing and community development skills. Does that make sense? And, if so, where do you find these kind of people?

(*Jackson*) Yes, it makes good sense. But when you ask where to find these kind of people, you're touching on one of the dilemmas that we're dealing with now, namely, as our funding ends, how is the community going to keep the program going? Are there individuals in the community who know enough to carry on the set of health promotion activities that we started? Training is one part of the answer. We bring people from the community to the center to attend workshops on, for example, community organization or nutrition education. Another part of our training effort is the production of manuals and videos. We also give presentations at board meetings to educate board members about the concepts like primary prevention and health education. We really are turning to people in the community and trying to train whoever is interested.

(*Chamberlin*) The problem is that we don't have those kind of resources here. All we can do is find somebody that at least has some of those skills to go in and work with the community to help them decide what their priorities are and implement programs.

(*Jackson*) I think it is a blend of skills that few people have acquired, which is why you either need multi-disciplinary groups or someone who's willing to learn new skills along the way. Social marketing applied to public health is a fairly new concept.

(*Albano*) If you were a state agency for example and wanted to develop this in a community, do you do a community needs assessment or would you put out an RFP and say we have funds and resources available if you need them.

(*Jackson*) Both approaches have been tried by the Center. The Health Promotion Resource Center is using the RFP approach. Although the funds are administered by the Kaiser Family Foundation, the HPRC staff are responsible for assisting communities in taking advantage of the available funds and resources; they provide technical assistance from the proposal writing stage onward. In fact, the major function of the HPRC is to assist communities in initiating and maintaining health promotion programs. It seems to be the case that not all communities have the necessary blend of skills and so the HPRC provides funds plus daily or weekly contact with the eleven funded communities. The community staff call with questions like "How do I design a questionnaire" or "What stop smoking programs are available?". The HPRC staff spend considerable time on the phone; in addition, the community staff visit the Center on a quarterly basis. Representatives from all of the funded communities were at the Center in October, for example, to learn about community organization. It's this training and support system that backs up the RFP process.

(*Chamberlin*) Ideally, the State Health and Human Service Agency ought to be the resource center. They ought to have a couple of people on the state level that could work with local communities.

(*Jackson*) Yes. The Associate Director of the Center and many others within the Center believe that the existing health agencies ought to play a strong role in health promotion planning and support. The question is how to change the system to integrate this new set of responsibilities within the state mandate.

(*Weil*) Could there be a blend of state and university? Because in Maine there's a university medical center so that if we wanted help with the production of audio visuals or certain kinds of promotional materials there are resource people within the university who can help provide the technical assistance and some of the actual person power to get it accomplished. In that way the state and university could work to provide the necessary resources.

(*Manoff*) The resources that you need are around you. Here in your University there are qualitative research people and it wouldn't surprise me if somewhere outside there isn't already a profit making organization, doing research projects. And if it isn't here in Hanover, which it probably isn't, it's not too far away. Then you have your university film people and if you don't have it there, you'll find in a nearby community some advertising agencies with people who have the skills to turn out the materials you need and most of them are ready to do this pro-bono because it's like the advertising council which works on these campaigns free of charge nationally. There are now local agencies that love to do this work because it stimulates their people and it also satisfies their souls, they get a chance to do some good. So if you just reach out and identify what you need in the way of resources, you can find out where they are.

(*Jackson*) That's a good point. When you ask the busy members of our board why they're involved, they say: "We're here because we like to feel like we're doing something good for the community."

(*Bauer*) One of the things that occurs to me is that in our three states, this sort of expertise is being applied, in the area of tourism promotion and in trying to get business to come to the state. I assume that there is a research and technical infrastructure to support and perhaps there is some way to tap into that.

(*Weil*) I think it's very practical to tie into that because what they want to promote is the state with a good environment, with a good place for businesses to come. They want to be able to say these are healthy communities to live in so I think tapping into that resource is very practical.

(*Manoff*) The only problem you're going to have is you have to put something into it. You have to get to understand the dynamics of social marketing and it behooves you not to think in terms of what commercial marketers do with the same resources. The local advertising agency you may engage is trained on a different basis. They work with different problems. They're working with products that are essentially parity products. The function of advertising is competitive. It's to switch people from brand A to brand B when there is very little difference between the two products. Therefore, they resort to imagery, you know, sex and dancing women and beach balls on the beach and people diving into pools. They hope that there will be a positive associative engagement and it works. Now having been weaned on that function qualitatively such people are not really tempermentally or intellectually equipped to work on the problems that we have to deal with in the work of health promotion where you're dealing with substantive issues and substantive information and material that makes a critical difference if you don't get it across. Now that's where your engagement in the work is so important, not to stifle the kind of creative work that these very talented people bring to bear on your own message, not to stifle that, but just to be sure that they stay within the strategies, that they don't go flipping off and giving you a very funny idea that has nothing to do with the problem you're dealing with. You know they give you beautiful solutions to problems that don't exist and you don't need that. So you have a responsibility in learning how to work with such people. But you know it need not be frightening because the way to begin is to begin and the only way you're going to get good at it is to begin to do it. You're going to be a lot better the first time you do it, than you will without doing it. The second time, you'll be even better, and about the tenth time you're not going to have to invite people like me and Christine to this meeting. Then you'll come to our meetings and tell us what *you've* been doing. That's what happens. The people working in Stanford, most of them had no previous experience. Am I right?

(*Jackson*) We all know one or two disciplines well, but basically you're right. A key point is that we learn from one another, especially because of our multi-disciplinary nature. I've learned a lot about heart disease and the physicians now sound like psychologists. There's a real mixing, but it takes a lot of exposure to one another and a lot of learning across disciplines so that when you work with someone who is a producer or designer you understand their language enough to know what they're talking about and enough to be able to feed into their ideas the sort of checks that you need from a theoretical point of view.

I'd like to show you one other project that we're working on. The idea came from the fact that the communities were gearing up to do cholesterol screening and the TV stations thought it was a great public relations tool and were going to give it a lot of air time. We thought there would be an important need for patient education and followup as part of the screening program. We went to the medical society and asked how prepared they were to respond to the referrals generated by a community based screening effort. They said they would need some help with patient education because they really don't know how to do it well since it's not what they've been trained to do, nor is it what they've got time to do. We then went back to the many sponsoring organizations and over a series of meetings decided that the best way to handle patient education was to encourage physicians to actually refer patients to the various cholesterol lowering education resources available in various places throughout the community. We listed these resources on a prescription pad. The physician was asked to discuss the different options with the patient; to jointly determine whether the patient would benefit most from self-help materials, group classes or face-to-face counseling. The physician could then actually prescribe on pad the activity desired by the patient. This simple prescription pad illustrates several aspects of community organization and intervention work. To get this pad into use, we needed to: (1) work with physicians through the Medical Society, plus recruit 80 physicians to use the pads; (2) collaborate with several community agencies, including the local hospitals, the Heart Association, the Red Cross, the TV stations, the Chamber of Commerce, the Visiting Nurses Association, a grocery store chain and a pharmaceutical company, and (3) determine what educational resources were available and get the representative agencies to agree to be on the pad; (4) be certain to provide enough options to meet a variety of educational needs. Another aspect of this project worth noting is connectedness between the educational resources, the prescriptions, the television coverage, and the public screenings. The television coverage, for example sent people to the doctor or to a screening; following testing by either their doctor or at a public screening, people were routed to educational resources. If they started out with a self-help kit, the kit sends them to their doctor or a screening, and so forth. There really is a lot of networking, so that one way or another people get exposed to the entire program. This project is an example of pulling together a number of community organizations to achieve a single goal, which is to get people screened, find out whether their cholesterol is too high and provide followup educational intervention.

End of Dr. Jackson's Presentation

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The Ounce of Prevention Program in Illinois: Empowering At Risk Families Through Community Based Family Support Programs

Presentation by Katherine Kamiya Rubino

My role at the Ounce is as associate director for Programming Community Services and in that role I oversee our direct service work with community agencies and our training and technical assistance program. I will be able to speak a little bit to the research and evaluation questions that I think are pertinent to this but not as well as some of my colleagues back at the Ounce.

The Ounce of Prevention Fund is a public-private partnership designed to empower parents in low-income communities through the development and implementation of comprehensive family support programs. It is based on a philosophy of primary prevention and it's aimed at *preventing* family dysfunction and reducing those problems most strongly correlated to it such as child abuse and neglect, teenage pregnancy and parenting, infant mortality and morbidity, unemployment and family violence, *protecting* healthy coping strategies both within an individual, within family units, and within communities; *promoting* the optimal development of children and families and those community services which foster and support families. This 3-pronged approach underlies all of the work that we do, both in direct services, as an administrative/fiscal agent, and also as a spokesperson for children in our state. The Ounce develops community-based programs for working, single, and teenage parents, pre-teens at risk of early pregnancy and their parents, and stressed low-income parents in over 40 communities across Illinois. In cooperation with the State and with local community groups, the Ounce develops non-deficit strategies which enable families to help themselves and to encourage their neighbors and communities to adopt and support this type of structured self-help programming. Innovative models of service delivery include school-based medical clinics, a child sexual abuse prevention program, a developmental screening program, a family support program located in a factory, and a network of community-based teen parent programs around the state. In addition, the Ounce conducts ongoing evaluation and research as well as a large training and support program to enhance our program development and to evaluate the effectiveness of our service.

The discussion today will focus on four levels of activity. The first will examine the state's role in setting the stage for innovative local programming and the process of identifying local providers. I will talk about the system within which we do our work and the structural things that happened in our state that allowed this to happen because I think they will lay good ground work for some of the discussion that you want to have in terms of looking at statewide initiatives. The second will focus on the philosophy and programming strategies that we have used with individuals and families, emphasizing the use of trained peers and community paraprofessionals. The third will focus on the challenges of conducting research and evaluation with programs aimed at empowerment. And, finally, I will talk a little about how we are organized as an administrative entity.

The stage was set in Illinois for a new role in state and public philanthropy. Several movements came together in some ways quite coincidentally but in other ways by some sense of plan that really combined social and political forces. These sectors are well represented by our two founding partners, Irving Harris, the chairman of the Charitable Foundation of the Pittway Corporation, which is a multiproduct manufacturing company, and Gregory Coler, then the director of the Illinois Dept. of Children & Family Services (DCFS), which is Illinois' state child welfare agency. Illinois, unlike most other states, does not have a human services department. It has separate state agencies that deal with welfare and public aid, health and child welfare. These two men were brought together through a private request for grant support for a local family support program. What they found was that they both really shared a similar perspective on child welfare services even though they were coming from very different places. Both recognized the need to develop new models of prevention services and the opportunity to test their ideas. A partnership would share the risk of an innovative venture in which control of service delivery would reside in community based organizations rather than a government agency. With the challenge to match public money with private funding, the Ounce of Prevention Fund was created with equal contributions of $400,000. We were designed to look at innovative prevention strategies on a larger than single site basis and to fund evaluation research that could inform larger state policy as related to preventive childrens services. We started with that kernel of 800,000 dollars in 1982. We are now about an 8 million dollar initiative.

State funding mechanisms were modified to reflect the experimental nature of the initiative. Plans were made for a three year pilot period, subject to annual renewal based on performance reviews and the availability of funds. Funds were made available on a grant basis versus a fee for service reimbursement system. Guided by a statewide planning committee, we developed two requests for proposals, one for six service demonstration sites and one for an evaluation team. Six sites were selected in 1982 from a pool of 112 applicants in a highly competitive review process. Sites were all located in communities of high risk but they were varied by the type of community, both urban and rural; the target population, both teenage and older parents, the cultural ethnic background of the group served, white, black, and hispanics; and the type of agency base, both medical providers, traditional social service providers, mental health providers, and family support agencies. Illinois is a very unusual state and interesting for its variety. It is dominated by Chicago near the top of the state where about 50% of the population resides. The other 50% of the population is spread across the state. We have one very large metropolitan area and small towns, farming communities, and small cities. We have white, black, hispanic, and Asian populations. We have very wealthy populations and we have very poor populations. We have a wide variety of different settings which has provided a tremendous challenge to our research effort but a considerably richer pool of program information. An evaluation team was also selected in 1982 representing and combining the strengths of two universities, Northwestern University Center, for Health Sciences and Policy Research and the University of Illinois, School of Public Health. A 3-year evaluation was designed to study the effectiveness of service, the effect on individual participants, the development of programs, and the effect on target communities.

In 1983, something happened in Illinois that really changed the complexion of social services in the state and the scope and magnitude of the work we did. A major new initiative was created which reflected the combined influence of a group of concerned women legislators, service providers, the opportunity of special federal funds, and the early indicators of success from the Ounce of Prevention Fund's first year of operation. Governor James Thompson created a statewide initiative to deter teenage pregnancy and the negative consequences associated with adolescent child bearing and parenting. Entitled the Parents Too Soon Initiative (PTS), it brought together 10 state agencies of government. It was funded by the Congressional Emergency Jobs Bill legislation and designated 12 million dollars for direct service and coordination of public and private services. Governed by the human services subcabinet it divided funds among three primary agencies: the Dept. of Public Health which acts as the lead agency for the initiative, the Dept. of Public Aid, and the Dept. of Children &

Family Services. In Illinois there are about 24,000 births to teenagers every year from a total of about 180,000 births overall in the state.

Based on our early success with the six service demonstration programs, the Ounce was able to successfully bid on a contract to administer and implement the DCFS portion of the Parents Too Soon Initiative. In December of 1983, we awarded additional grants to projects that were targeted specifically at adolescent parents. Service demonstration programs that were started the prior year also participate in this initiative. So, while we remain a separate organization, we are about ⅓ of the service network of this larger state program.

The PTS as an initiative has continued and grown even though federal dollars have diminished. We have replaced one time funds with ongoing maternal and child health and social services block grant money as well as state general revenues. This year the DCFS/Ounce appropriation was reduced by 2 million dollars because of a decline in the federal funds. Illinois was in a massive fight for a tax increase which it did not get. As a consequence, the state legislature voted to approve budgets of all state agencies at prior year levels. This effectively reduced our effort in Parents Too Soon by 50%. Literally, at the 11th hour, a special bi-partisan congressional group put together a funding package for those services in a climate of tremendous austerity. We were very pleased at that level of support. I think this was really a test year for Parents Too Soon and the fact that we were able to mobilize bi-partisan support in the face of a highly organized opposition from the political right is a testament to the fact that we have worked very hard at the community and state level to develop a broad base of support, not only for these particular services but for prevention services in general. The current Parents Too Soon budget is 15 million dollars which represents a modest growth since its 1983 start. In addition to the Human Services Subcabinet, a Parents Too Soon Interagency Task Force composed of representatives of the 10 state agencies that serve adolescents meets on a bi-monthly basis to coordinate activities and to identify problem areas. Parents Too Soon activities are coordinated by a staff of 10 members who are housed in the various state agencies that participate in the initiative.

(*Albano*) Do you have an adolescent health office in the division of public health?

(*Rubino*) No. Next what I'd like to talk about is some of the preventive program strategies that we have utilized, both in our Parents Too Soon effort as well as in some of our other work. The

Ounce currently administers 37 community based family support programs in Illinois as a part of our Parents Too Soon effort. We serve about 4,000 families in voluntary programs that are open to all eligible participants in the targeted communities. Our programs are divided into five service components that are fairly broadly defined.

The first is *Parent Group Services* designed to provide child development, child health information, and emotional support to young parents using a peer support model. Many of our programs use the Melds Young Moms model (MYM) that was developed in Minnesota. Groups of 8 to 12 new mothers meet weekly for one to two hours. Groups are designed to last for two years and begin as early as possible, some prenatally and some at the time of birth and continue to the time the children are about 2-2½ years of age. Groups are facilitated by two carefully selected and trained community women, many of whom have been teenage mothers themselves and have successfully negotiated the early years of their childrens lives. These volunteers are supervised by a site professional who has been trained either by Meld in Minnesota or by a member of our staff who is now certified in that model of parent services. The groups include presentations, discussion, and modeling of behavior. The agendas for those meetings are set both by community facilitators and by the group members. There is an extensive curriculum and support system for both the facilitators and the young moms but there's a considerable amount of flexibility about how it is implemented. While you have the support of a structure, you do not have the limitation of prescribed lessons on a schedule. This balance of structure and flexibility has been an important factor in serving teenagers. Child care services, a balanced meal or a light snack, and transportation are usually provided as support services. We do have a number of programs that operate in schools and in that setting some of those support services are not necessary because the participants are already there. Most of our groups are located in community locations, however, and those support services are quite important in keeping participation levels high. The program is assisted by a community advisory board with representatives of business, religion, education, medicine, social service, and the general community. This is a way of ensuring ongoing community input and feedback, a recruitment strategy for participants, and a mechanism for community involvement and support. Many of our programs get their meal service donated by local church groups or by local community groups, transportation services are often provided as a function of some kind of voluntary effort that is either specific to our program or is part of a larger volunteer effort. While we do pay for certain certification, training, and other program support services, the cost of operating the program is generally fairly nominal.

Home visiting is the second component that we fund. It is designed specifically to reduce the isolation of pregnant and parenting women, to link families with community resources, and to provide home based information and support services. Home visitors come from a variety of backgrounds with differing levels of formal education. They range from Master's level in social work to community para professional women who have never worked before outside of their homes. While they do range widely in terms of professional and educational experience, they are very similar in terms of their commitment to serving communities, their knowledge of community resources, and their caring quality about the way they do their work. The intensity of home visiting varies widely depending on the local community agency. Community demographics and other available services dictate in large part how it is used. In a rural community, which is the large part of our state, home visiting may be the primary service that is funded through a program because to get people physically together for a parenting group, would require about a half a day of driving around a multi-county area target community. Home visiting really plays a very different role in this setting than it may in an inner city community where it is a primary outreach strategy and/or crisis intervention mode but where most services are provided in a central facility like a drop-in center. One thing that is common in all the home visiting programs is the caring nature of the relationship between the home visitor and participant. I recently participated in a conference on youth employment initiatives for young pregnant and parenting women. And one of the common themes that many of the youth delegates at this conference talked about was the family-like quality of their involvement with programs. This program character was very different than other youth employment initiatives many had been enrolled in previously. Programs strengthen existing family systems and sometimes fill a vacuum in young people's lives of a family-like quality of expectations, support, caring, and nudging to move forward.

The third component of our services is *developmental childrens services.* It has two parts. The first, is a pool of money to provide high quality, consistent and stable care for infants and toddlers in order for their parents to return to school, to participate in GED programs or to allow them to participate in job training or employment initiatives. Our funds provide a very limited number of child care slots, both on-site and in community locations. Day care has proved to be a critical service but one that has been very, very difficult to manage. Day care is divided among several state agencies in Illinois. To make maximum use of our child care funds, we attempt to place children in other government subsidized child care programs. We have been successful in placing a number of young families into child care either with our funding support or through our brokerage of existing resources. We have not been successful in encouraging the expansion of the number of available day care slots in the state. This is an area that needs considerably greater focus than we have been able to provide. The second part of our children services are program activities that are directed specifically at young children or parents and young children such as part-time playgroups, mother-child interaction groups, recreation groups for parents and young children, and other child focused activities.

Our fourth category of services is called *Other Family Support Services* and it really is a catch all category that reflects special program or community needs or gaps in service that are not otherwise funded. They range widely from medical services in one location to recreational and other social services in another.

Our last category is *primary prevention services designed to prevent initial pregnancy.* Very soon after we began our work with pregnant and parenting adolescents, our service providers, advocates and detractors in the community began raising concerns that one unintended consequence of our programs was making teenage pregnancy quite appealing. We were mobilizing tremendous program efforts and resources to pregnant adolescents. We needed to look carefully at what message was being heard by communities. We gave considerable thought on a philosophical and operational level to what we were doing and why. We were quite clear in our message that the teenage years are not the optimal time for most people to start a family. However, if a decision to become a parent has been made, we wanted to try to help individuals become the very best parent that they can. In our second year of operating the Parents Too Soon initiative, we developed a special category of funded services in primary prevention. These fall into three categories. The first, are *programs that are directed at youth*: family life education classes, peer education programs, and the use of audio-visual or board games that help young people understand the consequences of their sexual decisions and the responsibilities of parenting. The second, is the *training for adults who work with youth*, like boy scout leaders, girl scout leaders, religious group leaders, and other people who have direct contact with young people using materials that have been developed in-house like the Octopus Program and other kinds of products that are designed for trainers of trainers. The third approach is, *broad based community education*, in terms of looking at prevention of teenage pregnancy as one of a number of consequences of risk taking behaviors.

In addition to the programs that we administer under Parents Too Soon, we have a number of other service initiatives. The *Family and Community Project* is a factory based support program. It serves about 200 assembly line workers at the BRK Electronics Factory from primarily Puerto Rican and Mexican backgrounds. The program has included parenting groups, lunch-time speakers, english as a second language, a latch-key program, a summer day camp program, crisis intervention counselling, and advocacy. Federal funding for this project was short-lived and we are pleased that the factory has agreed to continue the project in a slightly scaled down version. They did find it quite helpful in terms of employee satisfaction, reduced absenteeism related to family crises, and a sense of commitment from the factory to serving families.

Toward Teen Health is the name of our school based medical clinic program that we operate in three inner city high schools in Chicago. We have gotten, unfortunately, the most publicity for this part of our work distinguishing ourselves from the other school based medical clinics. The Illinois state legislature passed a bill at the end of the summer legislative session restricting state monies from any school based medical clinic that provided family planning. The governor did veto that legislation so for this legislative session that threat has passed but we expect that it will come back again soon. The strongest voice of support for the clinics came from the community advisory groups that are formed in conjunction with the clinics. It is the first time ever that some of the legislators have reported getting more mail from community groups as opposed to the Right to Life groups in Illinois which are very, very well organized. Communities did take a very active role in speaking up for their right to vote for and establish these clinics. The clinics do provide comprehensive medical services a fact that is often lost in all the publicity. For example, the first headline that came out about the clinics was "The Pill Goes to School." Eighty to 85% of the medical services that are provided at the clinic are unrelated to family planning. I think this statistic speaks clearly to some of the larger adolescent health issues that were raised in presentations earlier this morning. We are finding a large number of chronic illnesses that have not been previously diagnosed. Youth in high school, at 15, 16, who are legally blind and who do not have glasses, youth with very serious hearing defects, diabetes, and other forms of cardiac risk.

Young men and women are about equal users. The three clinics have started over a three year period of time and so we do not have very complete information on the most recent two. One clinic is just opening now. In the oldest clinic, that has been operating about 2¼ years, there is an equal mix of students. We have about 90% of the students in the school registered for the clinic. All of the services that are provided at the clinic do not require parental consent. Title X family planning services do not require parental consent. Even with parent consent some persons are concerned that the schools are the physical location for these services which they feel are not the business of schools at all.

We are also a *Headstart* grantee, serving about 700 children every year in and around the Chicago area. Three of our programs are directly affiliated with Parents Too Soon sites. Headstart was a way to extend services to at risk families so that children could be served from the prenatal period through entrance into school. Our fourth site is one in Will County which is the county adjoining Chicago. We have a very large Headstart program there and are hoping to marry it to a pool of Parents Too Soon money that we hope will be available next year.

The Center for Successful Child Development (CSCD) is our newest pilot program and is an early intervention program for families with young children in six buildings of the Robert Taylor Homes Project. Robert Taylor Homes is the largest housing project in the United States. It has 28, 16-story buildings. We are going to be working in six of those buildings providing comprehensive services to families with children born after the middle of this year, hoping that in five years those children will present themselves to the Beethoven Elementary School as a well prepared cohort entering kindergarten. It is obviously a long-term, expensive project that is just getting underway now. Chicago is involved in a major disagreement with the federal government about who is going to control the housing authority. Charges that it has mismanaged have prompted the federal government to take the unusual step of taking back control of it. We seem at this time to have local control for the immediate term. Since the CSCD site will be located in the housing project, the fighting back and forth between the feds and local authorities has slowed down its progress but should be opened by the end of this month.

The *Developmental Program* is designed to teach community lay workers to conduct a screening program for young children served in our Parents Too Soon program and to identify potential handicapping or disabling conditions which need further assessment by child development professionals. We use two instruments in the pilot. The Denver Developmental Screening Test looks at standardized measures of developmental milestones and Parent-Infant Observation Guides which we have developed internally that look at the more subtle interactional characteristics between children and their caregivers.

The *Teenage Single Parenting Initiative* is a youth employment program which involves six of our Parents Too Soon sites. It has funding from the Illinois State Board of Education under the Carl Perkins Vocational Act. It is looking at both on-site and brokered models of services for single teenage mothers and getting them from dependence on public assistance into education and employment that will lead toward a path for economic independence.

Heart-to-Heart is a child sexual abuse prevention program which we have developed in response to the fact that many of the adolescent mothers in our Parents Too Soon program reported that they had had prior experiences of sexual abuse. We felt that their children were at considerable risk of abuse, not only because of their mother's experience but also because many of our mothers are single and they have a number of different men that move in and out of their lives. The overall goal of Heart-to-Heart was to strengthen the adolescent parent's ability to protect themselves and their children against abuse. The program offers 10 two-hour units over a 10-week period and it is embedded in our established parenting groups. It is lead by a former teen mother and a community woman who have either had an abusive experience in their own life or who are familiar with someone who has had that kind of experience. Key components included a journal, a group project, a community advisory group, and a referral and treatment support system. As a part of this project we conducted a survey of the adolescent mothers in our programs around the state. In a sample of about 445 mothers, we were surprised to learn that over 60% of the mothers reported that they have had some kind of abusive experience in their own past. It also highlighted the fact that young men and young women come to relationships with each other with very different expectations. Many of the experiences that were described were in the context of what would otherwise be called a dating relationship, some would be legally defined as child sexual abuse, and others would be more in the category of date rape. It made clear the idea of telling adolescents just to say 'no' to sex is quite naive. Details of the survey are described in a pamphlet on sexual abuse available from the Ounce of Prevention.

In addition to the programs that we offer, we also have a training and technical assistance component to our work. It is an important way of sharing knowledge among the service providers in our network, linking people to the knowledge that is being generated in meetings like this, as well as an essential component of service delivery when using community paraprofessionals. Training is provided both on an agency, regional, and statewide basis to our grantees and to other involved community agencies. We use both our own staff and outside consultants to conduct sessions. A magazine is part of our training resources as well as part of our community educational and public relations resources. It is a way of sharing some of the information generated within our sites across a broader spectrum of people. We have several other resource materials that we have produced:

Deep Blue Funk and Other Stories is a book of 15 vignettes about black teenage parents who talk about their own lives and what it's like to be an adolescent parent.

Choice is the Mating Game is a one-hour video tape that is done in the format of a fantasy game show. Two adolescents go through some questions and decisions that they will need to make about their own emerging sexuality.

OCTOPUS an acronym for Open Communication for Teens and Parents Understanding Sexuality is a church based program for getting youth ministers involved in sexuality education.

Home Visiting as a Prevention Strategy in Family Support is an introduction to the topic of home visiting and a guide for setting up a home visiting program.

Salute to Teens is the name of a booklet and program that is a community education campaign that focuses on the positive involvement of teens in a community.

The third domain of our work is *research and evaluation.* The tremendous flexibility in program development which we have encouraged has created quite an evaluation nightmare. We have learned quite a lot from the research that has been done so far and we are at a point now to refine our research questions and look more carefully at how and what we do. Our research activities are an integral part of our effort and reflects different commitments in the research area.

One level, is documenting community needs and concerns. The survey we conducted regarding the prevalence of sexual abuse is a good example. A second level, is program accountability. As funding for community based programs becomes more difficult to obtain, there is an increased demand for empirical evidence that services are effective. The Ounce has a participant tracking system that serves the data needs of government funders, legislators, our program and research staff, and the local sites. The tracking system is a provider driven evaluation system which collects demographic and epidemiologic data on participants at intake, 3 months, 12 months, and 6 month intervals thereafter. Service utilization data is also collected on a monthly basis. We believe that were in the process of creating the largest data base on adolescent parents around the country. We have over 6,000 adolescent families enrolled in that system already. While there are many problems with our tracking system, we are beginning to look at some interesting correlations and indicators of positive impact as a way to design some outcome studies that will be more definitive. Fifty-eight percent of those participants who have stayed in programs 12 months or more have graduated from high school or are continuing in high school. Twenty-five percent of program participants are employed, either part time or full time. Seventy-five percent of those participants who were not previous users of birth control are now regular users. Three percent of the families are considered at high risk of abuse and neglect which is a low percentage.

Another area is applied research in child development. Our research department conducts studies that bring together child development and social policy. We have recently completed a child care study that looked at developmental outcomes of children of teenage mothers and different patterns of child care, in a home, in a center, and mixes of those different forms of care. Findings from this study are being used to inform the design of service delivery systems for adolescent parents as well as some emerging issues in terms of quality control.

The last area is really program evaluation and our tracking system data is beginning to inform more carefully constructed research questions. We have conducted a few pilot studies of small programs in our service network. One was called the Peer Power Program which was designed to reduce sexual activity among high risk middle school females who had older siblings who are already teen parents. It combined a process evaluation and an outcome study which looked at program effectiveness as well as a description of how the program had evolved over time.

In order to better understand how the Ounce operates, I would like to describe our administrative structure and our relationship with subcontracting agencies. We do continue as a public/private partnership. Irving Harris has continued as our private partner and board president and Gordon Johnson has replaced Gregory Coler as the director of Department of Children and Family Services, representing the public sector. The partnership has proven to be quite successful in mobilizing resources, implementing a wide variety of prevention services and taking risks that would not ordinarily be taken with public sector funds alone, and in the training and research areas. It has also served as a spokes person between individual communities and the statewide system as a whole. Approximately 85% of our funding comes from public sources, as a combination of state, local, and federal money. The 15% of private funding has levered quite a bit of public money, starting from an equal basis of 50/50. We are a 501(C)3 organization and, therefore, we are governed by a board of directors in addition to having public and private partners. We have a National Advisory Committee of prominent educators, researchers, and clinicians to help us form our service delivery strategies as well as systems. Internally, we have an executive director and four operating divisions: planning and development, research, program and community services, and fiscal operations. We have an administrative staff of about 25 people who are located in two offices, one in Chicago and one in Springfield, Illinois which is our state capital. We employ about 25 staff who are involved in direct services and some of the pilot programs that we directly operate. The partnership model is replicated in our relationship with local service sites. Local agencies have a 10% matching funds requirement that includes both in kind services as well as cash contributions. In addition, we play an equal role as program developers and funder/monitors. We wear multiple hats at one time. We are actively involved in the delivery and design of services. We have a field staff of six people who work with our 37 program sites and who are there on a regular basis to look at what is going on, to see what is going well, to see what is not going well. We use our contracts with sites as a mechanism for generating shared expectations, not as a mandate for what needs to be done. If something is not working after three months we analyze it and have a better way to do it, then the contract is modified to reflect a revised plan. This form of flexibility is not typical in the state system overall and reflects our more active involvement with community agencies. This has been a unique relationship, not without its tensions, but one in which we have created some very powerful alliances that have been both creative in terms of service as well as more powerful than as a single voice within the state. We operate in multiple domains and on several levels and similarly we expect that our sites will do the same. I think one of the differences between prevention services and intervention and treatment services is that in addition to seeing outcomes on an individual level, you also want to see a ripple effect in the larger context of the family and community and within our legislative and child welfare systems. As we measure our effects in prevention, we need to remember a three pronged description of preventing, promoting, and protecting and design evaluation systems that measure our effectiveness on all three levels as well as the multiple system levels which we want to impact. We believe that our work and partnership with community organizations and with the focus on prevention is the clear direction for public policy and services for young children and families. We really have a lot of models to pick from. The Stanford Heart Disease Prevention Program has many organizational similarities to our work even though we are in a totally different topic area. There are very old models of social service like the Jane Addams Community Center that we can learn from. In some ways we are going back, we are not going forward. I believe that we never really have new ideas, just old ideas with a slightly new twist that meet the mandate of something that is happening right now in a slightly different way. We need to extend and expand our vision of what we want for families to build not only on our perception of our problems but our perception of where we want families to be. This is necessary in order to have a vision for the kind of system and structure that is going to support families to get there. I think that is the major difference between a deficit based model, the classic half-empty glass and an empowerment model, half-full glass. This is a message that we have begun to get out in the state of Illinois. There are new initiatives that are beginning in Illinois that are quite fragile and it is uncertain where they will go. We are beginning to have state agency directors talking about the fact that they do not do enough on the helping continuum at the prevention end and that they need to devote more of their resources to preventive services. That is something that was rarely heard, even two or three years ago. That message is coming from leadership within state government, from the provider sector as well as from families. It is this type of collaboration and coalitions of people coming together that are going to be the powerful force to move us from where we are now to where we want to be. My remarks are based on the work of many of my colleagues at the Ounce. I have borrowed from our joint work and want to acknowledge their involvement and ideas. I would like to stop here and see if there are any questions that people have.

(*Weil*) You have Irving Harris and the public person who I gather has changed. Are they being invited to stay to talk to business and public sector representatives about this kind of matching money.

(*Rubino*) Yes. Up until a few years ago Irving was very active and in key positions within several operating businesses. While he still has active businesses interests he has pulled back from some of these roles. I was telling someone at lunch that I think he's replaced on a two for one basis, his business commitments with philanthropic commitments. Largely what he does now is talk to business groups, as a businessman, about their need for seeing their role in a human capital investment strategy. He is credible to those audiences. What he's saying is not terribly different than what early childhood educators have been saying since High Scope and Headstart but he is seen in a different light, as a successful businessman who has run several very large successful companies and who sees interconnections between things that many business people don't see. The governors office in our state worked with six other states to develop and replicate the Parents Too Soon model in their own state around the issue of adolescent pregnancy, so they have been quite active in promoting that as one way to look at coordinated state services. PTS was honored this year from the Kennedy School of Government at Harvard for innovations in state services and we got a hundred thousand dollar reward as part of being selected in that process of states who are trying more innovative strategies. The fact that we have 10 state agencies of government that meet on an every-other-month basis is nothing short of remarkable. The fact that they're actually trying to do joint planning and coordination of services, while still not a perfect system, I think is a testament to the fact people are beginning to have a different vision about services. It was made easier by a coming together pretty much by chance of a number of different circumstances. The Jobs Bill supplied a big lump of money with no strings attached and without a lot of lead time to decide how to spend it. This came on the heels of a fairly thoughtful series of reports about the special needs of adolescents and the fact that their needs did not reside in the mandate of one state agency. That you could look at adolescent pregnancy as a health issue, as an education/drop-out issue, as a social service issue, and as a welfare issue certainly helped pull some people together who would have probably taken longer to get to that place on their own. We also started with a tremendous advantage by having the participation of a leader in business and philanthropy who already believed in this issue and was willing to put his money where his mouth was and a state child welfare leader who believed that this was a direction that we ought to be looking at, and the opportunity of that vision coming together with a pool of money was an easy match to be made. I realize that we started with something that not every state starts with and we had leadership at the top which clearly helped.

I think the fact that we've been able to replace that federal money with state revenues and have been able to maintain or modestly increase on that level of commitment is a testament to the fact that people are pleased that it seems to be working. While there are still challenges in terms of joint planning, we have a model and a super structure so that the people from youth employment for instance are actually talking to the people in education about the fact that they're serving a lot of the same kids. It seems remarkable that this never happened before or that it did not happen as effectively as it's happening now. The system is not perfect and if I were going to erase the slate and start over again I could think of things that I wouldn't do the same way. But all things considered, I think that we have done a good job and the state has been quite active in promoting that kind of interagency collaboration and speaking about our experience at a number of meetings.

(*Weil*) I think that our state has an advantage in the fact that they are all relatively small in terms of population whereas you've got tremendous numbers of people to deal with and very large bureaucracies. In our state, at least in Maine, one can call a commissioner of a department or a bureau director and very likely have that person call you back within not too long a period of time. So there are advantages I think we have and I think some of our states are moving in some directions that are similar and the communication problems are not as horrendous.

(*Rubino*) I was on a forum a couple of years ago with someone from Virginia who was talking about some of the child abuse prevention activities that they were engaged in. She was the first speaker and talked about a very modestly funded effort that was done through a children's trust fund. I got up to speak and I said I don't really have anything to say except we do the same thing on a slightly bigger scale. The principles of what we've designed can be replicated in a lot of ways that don't need to be nearly as costly as the way we've done them and don't have to be done on the scale in which we've done them in order to be effective and important.

(*Manoff*) You talked about 37 programs, did you mean 37 communities?

(*Rubino*) We have 37 programs that probably serves somewhere around 60 communities. There are a number of our programs that serve multiple county areas. At the very bottom of the state we have one service provider, for instance, who serves a seven county area.

(*Manoff*) Do these programs diverge from each other in any respect? Do they reflect a growing experience and knowledge and therefore modifications?

(*Rubino*) They are all built on some of the same principles that I've talked about. We began at the same place but they've all taken a very different color within their own communities. The focus of service in particular programs may be entirely different. The manner in which a service is delivered may be totally different from one community to another. I think home visiting is a good example of that. Most of our programs that serve pregnant and parenting adolescents have a home visiting program. At an urban site, it may be one person who does outreach to hard-to-reach teenagers. It may be a community woman who has lived in and knows the area and residents and who gets them to a local community site. In a rural part of the state there may be as many as seven home visitors and they become the major way services are delivered. The content of the home visits are totally different there than in a city program. When I speak, especially to conservative groups, I am pleased to say that we fund both Planned Parenthood and Catholic Charities. Obviously their views about teen sexuality are quite different and what we try to do is create a variety of different ways in which community agencies that have different values and that reflect different segments of that community, can operate.

(*Manoff*) In your tracking, have you used any control areas to see whether you're having an impact on reduction in teen pregnancies?

(*Rubino*) Our original three year evaluation identified comparison communities. We were not set up nor did we want to run a control group study but we did want to have a comparison group. What happened was that it became so common to have adolescent parenting programs in communities that we didn't have anymore comparison communities of the same demographic characteristics as the programs that we ran. I think our evaluation efforts in that regard have been one of the underdeveloped parts of our effort. Illinois has seen a decline in the number rate and percentage of births to teenagers over a 5-year period. That trend precedes the creation of Parents Too Soon. I think that while we'd like to believe that we are part of that, it would be fool hearty to take credit for it. We do not have any definitive studies that would say that had this young woman or man not come in to this program this is what would have happened to them. I think that we're beginning to get to a point where we can look at subsections of our programs and more carefully design research studies similar to way the Peer Power Study was done.

(*Chamberlin*) One of the things that intrigued me about your program is that you got three or four state agencies to fund it. Are they still funding it jointly?

(*Rubino*) Different state agencies fund different components of the Parents Too Soon initiative.

(*Chamberlin*) But it's funneled into the Ounce?

(*Rubino*) No. Our portion of the Parents Too Soon initiative comes directly from the Dept. of Children and Family Services.

Other parts of the pool of money for Parents Too Soon come from other state agencies budgets but at this point, except for the administrative and coordinating function of the program as a whole, there's not a co-mingling of state funds. At the administrative level for the 10 staff members that I talked about who coordinate the program, there is shared agency support. They are physically located all over the state and in different state offices. So there's four people at the Dept. of Health and there's three people over at the Dept. of Children & Family Services. Some of the people who sit at Children & Family Services aren't funded with Children & Family Services money, they're funded with public aid money but DCFS had the space so they've been put together in that way. At our level there's not that co-mingling of funds to particular grantees. Many of our community providers are double grantees though of various parts of the initiative. We may fund the parenting family support education parts of their program and public health may fund the well-child and family planning parts of their program.

(*Chamberlin*) So they haven't given up control of their money?

(*Rubino*) They haven't given up total control of their money, although they're beginning to edge toward some pooling of funds and joint planning. We haven't eliminated territoriality here but there are beginnings of coordination in a different kind of way. In terms of the grant making process, there's involvement by representatives of the 10 state agencies which in the past would not have been done. If public health was issuing an RFP, public health people would have reviewed the responses to that RFP, they would have made the decisions alone and given out their money. Now there is an interagency committee that's involved in that review process and while that's not the same thing as everybody putting dollars into a shared pot that then gets divided back out, it is beginning to look at the expenditure of funds in a more coordinated way.

(*Bauer*) One of the things that I'm struck by is that you've been able to bring a lot of different programs together under a very catchy name, that's relevant. It's a name that is easy off the tongue, it tells what you're doing, and it has a big advantage over state programs that are saddled with horrible acronyms and initials. Have you found that as the program has gotten large that there is a sense of that identification among say the man on the street? Do a lot of people in Illinois who are not involved directly in human services know about the Ounce of Prevention and has there been a generalized sort of halo effect or spill-over effect from that?

(*Rubino*) There is some. There is a lot of confusion about our relationship and role with Parents Too Soon. Somehow we're together but people don't exactly understand how or why. Our logo is a little girl running with a balloon. Our public relations consultants have said it's an awful logo because it's so cute. But we are associated with that image and it is a very positive image. I think that there is a lot of common knowledge about it. The fact that Mr. Harris does a lot of public speaking and the fact that he is an active philanthropist also gives him access to the media which puts us in front of the press.

(*Bauer*) So it's on TV and in the newspaper with the logo and all of that?

(*Rubino*) I don't think that we have done a very active job of promoting ourselves. What we have done is tried to promote our local service programs and through them, have some visibility. I think that we've seen the down sides of that when it's come to funding and when people have to hear again the fairly long explanation of the relationship between the Ounce and Parents Too Soon or other pools of money. I think that we're actually going to take a slightly higher profile in the state, but we have not actively tried to profile ourselves as much as we have tried to create visibility for our service initiatives.

(*Bauer*) The same name permeates the entire state though is that right? All of the programs share the same names?

(*Rubino*) No, they don't. Most have different names selected by the local site. Selecting a program name has been a very instructive process for us. Many of the agencies that we funded had not worked actively in the area of prevention before and they needed to work very hard to change a community image of themselves as a treatment provider. One of our agencies that comes to mind was a traditional provider of 0 to 3 services. They had a very active program for handicapped children and they needed to create a new name, a new identity, and had to build a new entrance to their site. Families were coming in and they were going by children who had spinal bifida and who were paralyzed and who were never going to move on their own. Teenage parents were not going to come through that kind of introduction to a place and a program. The agency built another entrance to the building with a new identity in order to create a more health promotion image, not a deficit model image. Names have been very important. All of programs have a contractual requirement that on their literature it needs to say, a program funded by The Ounce of Prevention Fund (if they're part of Parents Too Soon it says as part of the Parents Too Soon initiative) but they are not all called Ounce of Prevention Fund programs; in fact, none of them are called Ounce of Prevention Fund programs.

(*Jackson*) That's been something that the Health Promotion Resource Center has encouraged the 11 funded communities to do once they get their coalition together: to define who they are and come up with a sense of identify and a common mission. They require these coalitions and boards to come up with a logo and come up with a name for stationery and all of that because they think that that is how you identify who you are and what your role is and that kind of recognition is important not only to the community but to the people who are associated with the program. An example is the Heart logo that we've used in the community for years. When people see the heart, they know it's us and they know it's Stanford and sometimes that's all it takes to get them to pick something out and look at it or attend to it on the television so we think it's important.

(*Bauer*) In Maine I'm told that the preschool project, of which there are some 16, are in the process now of all going from having individual names to one name. I'm not sure what the counter arguments against this are but apparently they've decided that it's better to have the solidarity and it will be less confusing to have one name for all of them rather than 16.

(*Chamberlin*) One of the problems that I see when you go the RFP route is the communities that can write the good grants get all the money, and the communities most in need often don't have somebody that can write the good grants. How do you handle that?

(*Rubino*) Well, we've had three experiences with various RFP processes. One, I think we did very well, one, I think we did pretty poorly, and the third was a very specific request for a proposal. The first was for the six demonstration sites for which we had 112 applicants. We put together a unique mailing list for it. We published it widely and because it was in tandem with the creation of a new state initiative we got a lot of free publicity for it to begin with. We had a multi-tier review process that was multidisciplinary and interagency based. It included both the paper review as well as a site visit. We weeded that pool of 112 down through several tiers of review. The first was having teams of local reviewers who reviewed only proposals that had come from their geographic region. The second was a more centralized review at both the state level and with us. Then we conducted site visits to about three times as many applicants as were finally funded. It is possible that in weeding the pool from 112 to 18 we probably lost some people who had some potential for doing something. But from that pool of 18, we then did a series of site visits that eliminated a whole other group very, very quickly distinguishing the great grant writers from the people who actually have good ideas and the capacity to implement them.

If you have the time, I would definitely recommend site visits. By putting together clinically sound teams you can tell in a very short amount of time whether the program has good potential to move with you, whether they reflect the kind of prevention/empowerment philosophy that you believe, and whether they are going to be a good partner with you in the model of the way you do your work. In the second round of our RFP's we got a huge amount of money that had to be spent very quickly. Our first instruction was that we would have to spend it within the federal fiscal year, which was in about three months from the time we received it. My suggestion was to open the windows of the office and throw the money on the street. When we found that we were going to have at least another federal fiscal year, we actually did come up with a better strategy. In that round of R.F.P.'s, we did not have time to site visit all the programs that were finally funded. In that expansion, we selected some programs that were not very good. They had very good designs on paper but when we started operating with them, they really did not have the kind of commitment to this type of service that we wanted to fund. They were able to market their work as prevention when, in fact, it was not. That's what they were told was the way you get money: just call it prevention even though it's what you're really doing already. After several years of working with them, some programs really did begin to understand what we were doing and were willing to work with us, but others were not and we stopped funding those.

A third solicitation process had several parts. First, you ask people for an indication of what their ideas are in a brief concept paper. If they are totally off base, then you do not ask them to submit a full proposal. You then proceed to a full proposal, either in tandem with technical assistance or a site visit or both. That seems to be the best way. You have the most time to develop a relationship with that site, particularly in the kind of relationship we expect with agencies which is the partnership model. We're not buying a commodity that's out there in the community already, we're creating a new service system and so that ability to work with us in a compatible way is important. I would recommend if you have the time, you use an RFP process which includes technical assistance and a site visit. Another RFP that we issued, a very small one, was to replace a program that we were dropping from service. We were interested in developing another service site in a particular geographic area in Chicago and so we did a very targeted RFP. In that situation, we literally visited everyone who applied and so we were able to get to know every applicant agency before we made that final decision. That site has moved along much more quickly than other sites not only because it doesn't have to compete, with other programs that are at the same stage of development, but also because we were able to be much clearer about what we wanted. Not only did we have more experience in selecting programs, we had more experience in operating programs so we could be more specific about some of the things we wanted.

(*Chamberlin*) Have you every gone to a community that looks like a really high need community but has not responded to your RFP and try and see if you can locate somebody in that community that might be responsive?

(*Rubino*) We have not done that yet but only because we didn't have funds. This year we had proposed in our application for state funding, a major program expansion into five communities in the state that have sizeable populations but no programs right now. They are very high need communities and we have never received any application from those communities or one that was even marginally credible. Our proposal was to go out into those communities, to learn the community landscape, to find some coalition of providers who wanted to work with us, and then to fund them. Because of the fact that the tax increase did not pass in Illinois, we did not get the money to do that. But I think that is our next strategy. The other thing that we've done is to use a community development consultant on staff to work with our programs as well as other community agencies to strengthen local agencies' capacities to raise funds within their own community, to involve the community sector in a meaningful way and to raise their technical expertise in grant writing. We have provided this service as a part of our training and technical assistance.

(*Chamberlin*) Is there one person that covers the whole state?

(*Rubino*) Yes. And that's done both in individual visits as well as regional trainings.

(*Weil*) Have you had applications come in from two or more agencies in a given community where you've encouraged them to form a coalition and become one applicant?

(*Rubino*) We have had a variety of experiences with coalitions. Our experience is very good when you have voluntary coalitions who come together under the mandate of their shared desire to work together whether there is a funding relationship or not. In the upper part of the state, we have community wide coalitions in five counties that are under the auspices of one grantee agency that bring together all youth serving providers in that community. They are not united by funding. People do not get funding from us to be part of this coalition, but our people who are funded do staff that coalition. What's happened is we've created in those communities a network of providers that knows each other by name, that knows who to call, that knows how to get access to service, and knows what's there. We've also created an advocacy organization that can identify what service gaps in that community and so we've created our own little mini organization there that both speaks for and reflects the community. That's a non-funding relationship except for the fact that we obviously have money in the community that pays for some of the coordination. We've had some consortias that have worked with us and most of them have not worked very well. Where they have worked well, there serving a relatively restricted geographic community and they have some kind of shared power system. Where they have not worked well, is when they are serving multi-county areas over a large geographic territory and get tied up in the conflict between their own agencies bureaucratic structure and a funding partner's obligations. We found that each agency requires their own sets of forms and their own sets of procedures to enroll participants. Then we come in with our money and we have our own set of forms and rules and regulations, and what happens is you set up just an incredibly cumbersome organization. Those consortias have not tended to last. We have funded some consortias over 3½ years and the last of those voluntarily broke up this last year at the recommendation of both members of the consortia.

We have also had forced collaborations where we have had two agencies in reasonably close proximity that were serving similar or overlapping populations. We used our money to leverage that kind of coordination but only at the expenditure of enormous amounts of energy on our part. While I think it's important to coordinate services, I don't think funding is the mechanism by which you accomplish that. You need to do that in a different kind of way so I wouldn't recommend that strategy.

(*Little*) I spent a week in Chicago doing MCH site visits in the middle of August a couple of years ago and I came away with bigness and confusion in my mind and the scope of what you're talking about. Can you, given the difficulty with outcome evaluation and measures, give me like two quick zingers of what you think your superstars are in terms of program effects? You know, if you had to say to somebody, "Here's where we've had an impact." Can you give me an idea of a couple of those?

(*Rubino*) One of the pieces of material that I brought describes a project called Salute to Teens. It is a community based project that recognized the positive achievement of teens in the community. I think that it really pulls together a lot of the lessons we have learned from primary prevention and has had a remarkable, direct effect on youth, direct effect on community organizations, and direct effect on this community. It has been piloted in western Illinois, in the Moline/Davenport area in what we call our quad cities area, between Iowa and Illinois.

It has been powerful in a number of ways. First, it gives a very clear positive message and that is the primary message. Not, "Oh, you kids, you're all turning into drug addicts. Oh, you're all killing yourselves." The teens who have been involved have a great sense of appreciation for that positive message. They are being recognized because they are young, because they have energy, because they do good things in the community, and because they're contributors. We have had a lot of feedback from parents, teachers, school systems and community agencies that participated, that it has had a measurable impact on young people who have been involved in the project.

I think the second is that it really mobilized community organizations to look at young people in a very different way. Instead of looking at them as culminations of problems that need to be fixed, they're looking at them in a much broader context and they're changing the way services are delivered, they're changing their involvement in other kinds of prevention initiatives because of this, and seeing that they are powerful players in a community system in a different way.

The third thing that has changed there is that specific things in the community have changed. The counselling system in the high school changed as a result of things kids said about what they wanted schools to do that they weren't doing. And so we saw change on multiple levels as a result of a massive one-week effort that is mounted every year and whose direct participants are not really youth but adults in the community. We have mobilized young people, we've mobilized the adults that are significant in their lives, we've changed the way organizations that serve young people in that community operate and we've created some new opportunities for change in the system that I think is different. I think that's a good example of a community based project that's really changed things. There have been other examples like the place where when we started a program we wanted the schools to be involved in referring adolescent parents to our programs. They said, "There aren't any adolescent parents in this community. There are no pregnant and parenting adolescents here." And two or three years later, they are inviting our providers into the school to do family life education classes for at risk groups. They are inviting them in to do the MYM program for adolescent parents.

I think on an individual level the gains are in much, much smaller increments. I think one of the problems we have had in our evaluation is that the changes we're looking for are big changes. The reality is that for someone who is engaged in service, even as a good user who is involved for a fairly substantial length of time, say two years, we are not going to change the way someone's life experience has been for 17 years in a two-year program. The pull of the communities that these kids live in are very, very powerful and where we see changes they are in small incremental things, such as: taking better care of their own children, the interval between their first and subsequent pregnancies is either greater or that they haven't had a subsequent pregnancy, they have a new ability to look back on their own experience of being parented and to understand it, to own it, and to feel control of it in a different way, and in a way that doesn't usually separate them from their family of origin. Where we've been most successful, we've strengthened that relationship with the family of origin, not made it more distant. And a lot of these kids have real crummy lives. When they tell you about all the things that have happened in their lives, you're impressed with the tremendous strength they display, the fact that they are still living. You think, would I keep going if this was what my life was? They talk a lot about coping. But the increments of change are small and they're primarily relational. I think relational with their children and relational with their families of origin. Sometimes it gets reflected in concrete outcome measures that they're better contraceptors, that they go back to school, that they have more ability to be financially independent, that they have a better knowledge of how to use community systems to get and broker the services that they need, and that they have a better sense of self-esteem, self-control, power over what happens in their own lives. But the increments, I think, are small.

(*Papiernik*) I'm very happy that you are answering the question this way because obviously you have been extremely successful in building a program and collecting money and making people participate but it's important to offer some kind of outcome measures, even of a social nature that you have just described. I would begin with that.

(Rubino) I think we have to grow in evaluation and there are some things that we can do. We can look at who doesn't stay in our initiative. Our programs are voluntary and we need to know who doesn't stay as well as who does stay. We can do comparisons across different levels and types of service intervention because it's very hard to live in a community in Illinois now where you don't get something if you're a teen parent. We have just completed a study that is still in progress that's looking at two things. One, is an intensive interview with 25 successful par-

ticipants as self-defined to find out from them what they felt was most meaningful in the services they were involved with. The second is looking at the database that we have in Parents Too Soon in comparing it with other national studies of teen parents. That's not a perfect kind of evaluation design but it is an important step. I think we're at a point where we can begin to be forcing ourselves into more rigorous evaluations.

(Papiernik) You should because it's impossible to accept that it's such a big program without an evaluation component. It should be presented without the precise evaluation even if it's obvious that the two year intervention is a very short interval.

(Rubino) We do have in our tracking system some life events outcomes that we look at that we think are positive indicators of program success. They tell us where to look more carefully, not necessarily that our program is the only reason that things may have changed in terms of stability of where kids live, their school status, their contracepting behavior, the status of their children in the developmental program. We do have this information but I don't think that we've looked at it carefully enough. We are doing that now with a new strengthened research team. And too, I think that there are other kinds of things that we have to do in order to answer very legitimate questions that we have about the way in which we do our work and what we ought to promote.

# # #

Addendum: Following are some excerpts about the early experience of the Ounce in developing preventive programs that are of interest. They are taken from a paper entitled: "The Ounce of Prevention Fund: The Development of A Statewide Family Support Program" by Harold Gershenson, Ph.D., and Judith Musick, Ph.D., that was presented by Dr. Gershenson at the annual meeting of the American Public Health Association in Anaheim, California in November of 1984.

. . . . The Ounce uses an ecological model in implementing prevention services. Service, in this model, can take place at three levels: the individual, the situational, and the societal. The individual level is the one with which most of us are most familiar. In serving the individual we ask, what can we do to help this parent be the best parent possible. By looking at the situation we open the question and look, for example, at the family and its resources. What can we do to strengthen this system. Again, this is familiar to most of you who have worked in service delivery. But we ask our service providers to also address the societal level.

We ask them to work with the systems within their communities, such as the schools, churches, and press to facilitate and support the change that is necessary to enhance family well-being. For most, this is a new and unusual role.

. . . . Rather than focus on programmatic details, I would like to spend the rest of the time discussing what we have learned about developing prevention programs. Of first and foremost importance is that we have had to train the service providers in the meaning of prevention. Our programs are set in many different service bases, medical clinics, social service agencies, churches, and youth service bureaus. Most have been committed to treatment of a psychological or physiological pathology, and some have been doing this successfully for over one hundred years. We require them to shift their focus from treating clients or patients to assisting participants. This shift is not merely semantic. It involves a change in attitudes and behaviors that are reflected in the way the staff work with the participants. Participants are in the programs not because they are ill, not because they are being forced to join by the courts, but because they want to be there, and because they want to learn. Program staff are to educate the participants, help them know their options, and assist them in making knowledgeable decisions. It can be very difficult for both administrators and direct service staff to understand this new role.

Agencies respond differently to this change in focus. Part of their response is dependent on their commitment. Support for the prevention program must take place up and down the organizational chart. Line staff cannot function unless they are encouraged by the agency administration, and the agency director cannot implement the program unless there is backing from the board of directors. To this end, we provide technical assistance and training at all levels. On request, we attend board meetings as well as provide training for program staff. Trying to provide support for these programs is not without its pitfalls. Often, we discover that what is presented as a program issue, is really a mask for an administrative or personnel problem within a particular agency. Then we must step back, because we cannot expect an innovative venture to flourish in an agency that has internal problems.

Our efforts in helping an agency shift from a treatment to a prevention focus is also dependent on the discipline in which the program is based. One site uses a large cadre of student pediatric nurses. Their professional training has instilled a positive attitude toward prevention, and they are trained in child development. However, their focus is on health issues, and we must work with them to look at the social and emotional development of the child. In a second institution, the staff are largely social workers with advanced degrees. They find it hard not to think of the parents as *patients in need of therapy.* We try to teach them to shift their focus to the parent-child interaction, and help the parent become more responsive to the child's needs. We want the service providers to empower the parents and to promote peer support.

We also work hard to insure that programs are community based. Programs must reflect the needs of the people who live there. This requires consultation with local leaders from the churches, from the schools, and from civic leaders. These programs will only survive and succeed if they are supported by their communities. We have discovered that developing programs and community support is an interactive process. The service providers must believe that this support is important, and believe that the community can contribute to the program. The community must come to share these concerns and use them to mobilize support for the initiatives. The community response is a function of both attitude and resources. The community must perceive the value of the program, which is generally dependent on the quality of the outreach.

. . . . Not only must the programs gain support from community leaders, they must also work with other social service agencies. And even more importantly, they must demonstrate to the mothers and fathers how useful their services can be. They must use their service base to change minds and solve problems. We have started programs in many communities where we have been warned that the population was very conservative and unwilling to discuss social problems, and we witnessed dramatic changes.

. . . . We have become increasingly impressed with the need for public relations. PR may seem peripheral to those of us involved in social services, but it is necessary if we are to change attitudes about childrearing. We encourage our sites to involve the local press in their activities, and we retain a public relations consultant to give them technical assistance. In July, one of our programs got television coverage for their Toddler Olympics. The push-toy race and other events were featured on the evening news. In another town, the project director became a television star when she convinced the local cable television station to let her host a weekly program about child development. Meanwhile we promote our cause on a statewide level. Last month we cosponsored a conference on adolescent sexuality, pregnancy, and parenthood to interest community leaders in this issue. Our conference was successful not only in terms of educating professionals and lay people from a variety of sectors about the issue, but also in terms of creating a broad base of support for the types of services we provide.

As advocates for creating community interest in healthy parenting and healthy children, we feel it is important to work at all levels and to reach the community from all angles. By educating social service providers, by educating community leaders, and by educating the citizenry, we hope to make a social climate where child abuse and neglect is not tolerated. We are an organization that has explicit values, and we feel it is important that they are voiced. It is not all right to hit children. It is not a good idea for teenagers to bear children. But this is a language of negation. In prevention we insist on emphasizing family strengths. We build on parent's desire to do the best thing for their children. By making family support a community responsibility, we strive to offer that Ounce of Prevention that is worth more than a pound of cure.

Social Marketing

Presentation by Richard K. Manoff
President of Manoff International, Inc.

Richard Manoff is founder and president of Manoff International, Inc., a leading social marketing and advertising firm since 1956. Mr. Manoff became interested in applying marketing techniques to public health following participation in a U.S.A.I.D. mission on nutrition education in India in 1967. Since there he has helped carry out projects in a variety of developing countries including Ecuador, the Phillipines, Nicaragua, and Bangladesh. He's a consultant for WHO and UNICEF and has been involved with an international code for marketing breast milk substitutes. Mr. Manoff has lectured at Boston University and Columbia and is the author of Social Marketing: New Imperatives for Public Health *published by Praeger in 1985.*

Mr. Manoff: I had more formal remarks planned but have decided to put them aside. I thought it would be important to tell you something about the roots of social marketing, which is a set of rigorous disciplines.

Social marketing, is a strategy to improve the quality of health programs primarily by improving communications. Every aspect of a health program involves communication whether for training, public education or instruction. It's a strategy to increase the reach of a program, to enlarge its scale so as to magnify its impact. At the same time it seeks a relatively high frequency of contact with target audiences, an important consideration under pressures to cut down the number of contacts per health worker because of constraints in funding and time, or lack of trained people.

Social marketing can also help to shape political will, without this programs are generally not likely to happen. To do that it is essential to identify the powerbrokers. In developing countries we sometimes fall into the trap of working exclusively with the Ministry of Health which is usually among the weaker ministries without decision making power. So often when all seems poised to go well, with the Minister of Health in favor of a plan, nothing happens. It is usually the same explanation: *the decision makers were not reached.*

How does social marketing work to accomplish this? Social marketing is like marketing itself, a demand strategy, a strategy for creating effective demand for a service. By effective demand, I mean a reaching out to get it. One of the problems with past health programs is that they are fundamentally supply-oriented. A facility and an infrastructure are established with the assumption that the world is waiting for it. But demand is not inherent in programs; it must be created. We didn't always appreciate this and I would like to tell a story to illustrate it. The apple was the source of worldly wisdom for Adam & Eve but in communication and social marketing it may very well have been the orange. Until the recent era, an orange was an orange, but almost a century ago, one unconventional California Orange Grower was moved to question this received wisdom. What was an orange, really? Was its place properly in the family fruit bowl? Who buys it? How do they consume it? Why?

So he went to the community to find out. He knew about orange supply. He needed to discover the magic of its demand. Now this reaching into the community helped him discover that the orange was not so much a fruit to be peeled and eaten but a fruit to be cut open, squeezed and drunk. That's how heavy orange consumers were consuming it. A glass of orange juice required 2, 3, 4 oranges so it was a tremendous marketing opportunity. Our orange grower decided to advertise, and the campaign was "Drink an Orange For Breakfast." He proclaimed this to a vast untapped market. By adopting a demand strategy, he shifted his communications focus from the product to the consumer. He no longer sold a fruit but marketed a consumer demand, a consumer want, a need, rather, for which the orange could ideally be positioned. He had a new objective. Not to sell supply but to satisfy demand. That's how orange juice was invented 100 years ago. The point: *not to sell supply but to satisfy demand.*

Thus, if among the people were to be discovered the insights to new market opportunities, then innovative techniques were needed to penetrate the hard crust of consumer resistance to the rich subsoil of consumer desire and motivation. The messages could no longer present only the facts about a product, a service, or a new behavior and expect that the consumer demand would logically follow. Now the message had to be positioned with a new sensitivity toward the consumer. That meant that communications planning would have to begin at the beginning of the project in the community and among the people. Now the historic U.N. Conference that you all know about, at Alma Ata in 1978, ordained the same new responsibility for communications in primary health care. For communicators the rule became, no more 'top-down programs'. Communications development had become a two-way process: *To communicate with the people in order to ascertain how to communicate to them.* It established the pre-eminence of 'feed forward', over 'feedback' — to listen and learn from the people in advance so that program design might benefit from that input. It was not to replace feedback but simply to minimize "feedback shock" that we're all familiar with: belated discovery of preventable error.

It always amazes me how absolutely pleased people are when feedback is rich. Wouldn't it be wonderful instead if it were *zero*, if everything were perfect and there were no changes to make in messages, booklets, and pamphlets. It's a kind of a health program masochism that delights in finding mistakes.

Now this kinship between commercial marketing and primary health care inevitably led to a sharing of methodology. The focus group interview is a case in point. Let me tell you how. It is a technique of commercial marketing. The focus groups are a combination of anthropological research and group psychotherapy. Six to ten people sit around the table and a skillful moderator, like a group psychotherapist, provokes interactive exchange opportunities. People will reveal much more to each other in an interactive situation than they will to somebody who walks in with a close-ended questionnaire and simply asks questions. You need a qualitative technique like the focus group when you're looking for the explanation of behavior. If you're looking for descriptions of behavior, than you need quantitative techniques, but they're really only updates on questions you already know. This technique of commercial marketing is designed to overcome the limitations of traditional quantitative research in which prestructured questionnaires treat people as respondents. The focus group empowers them. It empowers them as participants in this search — they bring forth unsolicited information that you and I as program planners may very well be unaware of. This innovation of commercial marketing has since been seized on by social planners, but there's even more that they want to share. First, this feed forward research, then following disciplines of message design based on insights derived from such research, ingenious uses of modern media techniques, and then in-process uses of evaluation. This explains the emergence of a new discipline we've come to call social marketing. You need to identify your target audiences and see what segmentation may exist there. You check out your concepts with them by conducting a searching inquiry in such way as to discover things you need to know for effective message design such as resistances that have to overcome. Incidentally, the secret of effective message design is dealing with those barriers. Simple problem solution messages are only restatements of your objectives and your goals but they're not messages designed to move people to a desire for the behavior change that you are seeking to promote. You must deal with the resistances that exist and unless you engage in this kind of feed forward research you'll never uncover them. In other words, social marketing, has as its objective and its opportunities:

#1) It can maximize awareness of health problems. There are a lot of people out there who don't know what they are suffering from. An example, is oral rehydration programs dealing with diarrheal infections in a developing country. It was belatedly discovered in some of the programs that the first thing you have to do is to invent the disease called diarrhea — It's not looked upon as a disease because it's so common. You can't walk in and deliver messages to the effect that this is a condition that needs treatment when in fact it's not looked upon with any concern.

#2) It can educate target populations on how to deal with these health problems.

#3) It can promote use of public and private sector facilities and services and motivate wide use of them. The most difficult job we have is to get the most underserved segment of our target population to use those facilities. They are the unmotivated. They're not the ones who will watch a television program for a half hour. They'll turn on a competitive station. This is why the short-message technique is a much better technique. You catch them before they can flip you off. The unmotivated are the most difficult to reach and they are really the ones you want to reach. Sometimes we end up so frustrated that we begin to fall into the trap of conceiving more and more programs that are designed to serve the population segments slightly above that group. I think there is some of that in your programs.

I'd like to talk about parenting a little bit. I'm not sure of any of this because I have only one days familiarity with what I've heard here. The question I would raise is to what extent some aspects of your programs are really meeting the needs of your most vulnerable and under served population segment. I think you would know this if you had engaged in the social marketing process and let the people speak out and tell you things. There's not as much ignorance out there in terms of the capability for analyzing what is needed as we sometimes imagine. For example, when I go into the villages of Tanzania or Bangladesh, I find they do a very good job of coping with what they have to work with. They have judgment and there are things that we must listen to if we're going to be effective in helping.

And, finally, #4 is to enlist the private sector, to engage in primary prevention programs.

Let me just quickly tell you about the disciplines of social marketing and then what I'd like to do is to run through some of the things that I jotted down today because I think you're really more interested in what you have to do than what I've been doing around the world. I've brought one thing to show you from Bangladesh that you might enjoy seeing by way of illustrating a good deal of what I've said so far.

I'm going to give you 12 disciplines of social marketing.

1) Identify the health problems and the marketing and message actions required for their solution.

2) Establish priorities and select affordable efforts. Set up a deferred schedule for all others. It's so easy to take on too much.

3) Analyze the distinct marketing message activities needed for each problem solution.

4) Pin point the target audience and its segments for each marketing and message action.

5) Conduct the necessary research on each marketing and message concept to determine current target audience attitudes and uncover potential resistance points.

6) Look at the sequence. That's important. Establish objectives for each target group and each marketing and message action.

7) Design the marketing and message actions.

8) Test the marketing and message actions for acceptability, implementability, comprehension, believability, motivation, and conviction. Too often, we promise what we can't deliver. That's a result of our eagerness to really want to be effective.

9) Revise and retest the marketing/message actions as necessary.

10) Construct the marketing distribution and message media patterns to achieve maximum target audience reach and message frequency. I don't think we do enough of that. We turn out booklets and pamphlets and informational materials. We call those media sometimes but they are really materials and need delivery systems, even if the delivery system is a person. We've got to be relevant and we've got to do some assessing as to how far that's going to go and how effective our reach is going to be in getting that material out.

11) Coordinate and harmonize with all ongoing programs — message harmony. There has been a lot of good talk about a need for coordinating various agencies in the field. The important part of that is to avoid message dissidence. People are getting enough dissidence in terms of advice from commercial advertising and

modeling on television and radio. You've got to use the same instruments that are having so much impact to get your message across.

12) Track the impact of each of these actions and modify according to findings.

I cannot go into detail about social marketing. The details are in my book. What I want to emphasize is "upfront" or "feed forward" research. I have the impression that this is negligible in you're parenting programs. If you had done more such research, I venture to guess that you would have discovered how very little sex appeal "parenting" has to your target audience. I think it's part of quality control. You become intolerant and a little impatient if those errors are to creep up and to be discovered once a program is launched. They can be prevented like a preventable disease.

In the book there's a chart that describes the social marketing process. That doesn't mean that all social marketing programs have to be planned with all those components. However, the penetrating analysis of the local situation gives you an opportunity to examine all the possibilities of the social marketing process and all the steps to ascertain the relevance and the appropriateness of each element. I recently attended a conference in Bellagio with the title of, 'Why Things Work'. There were people there from all over the world to describe successful family planning programs so that we might ascertain the reasons for their success. By the end of the week, with some very experienced people evaluating these programs from 6 or 7 different points of view, the conclusion was that we really could not tell why things work except that inspired leaders with talent and a pension for innovation, were involved. However, do penetrating analyses of a situation so you can get a good fix on what would be appropriate and then apply relevant strategies to that and keep things simple. Don't make them complicated with the over gathering of data that isn't useable or having training programs that are overblown in terms of what the people need to know for what they have to do. Do training in phases so that you don't put everything into one message. You have simple, single pointed messages that you build on. Life is complicated enough and the objective is to simplify.

Human resources are necessary in social marketing and they can often be found locally by those who know what is needed. You can go to a university for help with evaluation. You can go to the local television station, advertising agencies, production houses, and film schools for what their people can do best. Often these people are eager to work for a good cause on a voluntary basis.

Let me touch on some brief additional generalizations. Small scale pilot programs are a problem. Too often these projects take too long and by the time the results are in, their relevance has passed and the policy decision made. Also, they rarely prove to be replicable. We get so involved in wanting it to be a success, that the temptation of investing more personnel and money into that situation than you could possibly afford on a larger scale becomes irresistable. To prevent this, as soon as you know what your pilot program costs are, do a larger projection to see whether or not you can afford it for a larger scale application. This will provide a "no go" or "go" answer. The moment you go from a pilot project to a large scale project, you've got a qualitative change and much of what you did in the pilot project is no longer valid. Surveillance becomes more difficult, training becomes more difficult, and you must find some means to give you that mass reach which you can't possibly attain when you enlarge the experience.

I was very much interested in the whole discussion about the "Parents Too Soon" programs and I think that was making a point that I'd like to emphasize. The problem of primary prevention programs by their very nature is that they're tough to sell. They're all embracing as they should be, but that's not the way political will can be aroused to support them because it tends to priorities — like teenage pregnancy or AIDS. Only sixty thousand people have been infected with AIDS in the entire world but AIDS is getting major support and huge amounts of money. It's a matter of being at the right place, at the right time, with the right subject. I do believe that even in primary care programs you do have emphasize some single purpose campaign from time to time because there *are* priorities and priority programs can be used to strengthen the primary care system. It was difficult in Turkey, for example, to sell the government on financing their primary health care system until we came to them with UNICEF and an immunization program. We said Turkey could achieve an 80% immunization rate and perhaps wipe out these big killer diseases. They mobilized a national program and poured money into the primary health care system for purposes of immunization. When that campaign was over, the primary health care system in Turkey had been advanced five years in exactly two months. If you want to create a lightening rod, as it were, for primary prevention programs you must set priorities that are relevant and appropriate in terms of what are the most pressing health priorities and problems at a given time. In the developing world all kinds of support is possible for breast feeding promotion and oral rehydration because they are associated with major health problems. UNICEF pursues such a philosophy and helps to build primary care systems.

I do believe that 'parenting' as a banner lacks urgency. Frankly, you can't get me excited about it. However, if you told me, and I had teenage daughters or a son, 'help us with this problem of teenage pregnancy' – you could get me involved. I think if you came to me and said, 'drug abuse'; if you came to me and said, 'alcohol abuse'; if you came to me and said, 'heart disease and cancer', you would succeed. Could you have gotten that money for Parenting? No way. Now what I'm telling you is the essence of social marketing. You really have to visualize these things in terms of your various target audiences. You can't even get your consumers excited with it, let alone your funders. And Bob I have to say to you, I don't think "kindergartens" are a rallying banner for this either.

(*Chamberlin*) If you just pick what people are worried about then you end up with all these fragmented programs and you never get at the basic underlying problems.

(*Manoff*) I have the impression that you already have fragmented programs.

(*Chamberlin*) Yes, but that's because everybody is doing it for teenage pregnancy and drug abuse and whatever.

(*Manoff*) But isn't it helping to build the infrastructure?

(*Chamberlin*) Well, not really.

(*Manoff*) Well, then I don't know enough.

(*Chamberlin*) It's isolated little programs that never really get at the heart of the matter which is what's happening to families.

(*Manoff*) Well, let's put it this way then. We have to find a better way of presenting this and organizing it. Even if what I've said so far is inadequate, I believe the principle is sound. Unless you push to find that answer to it and to find the presentation that's going to trigger it, you won't be successful. What I'm saying is I want us to be successful and I think you have to have single purpose efforts from time to time or you can't rally your community organizations. I mean when you're going in on Parenting with some all embracing program, it's extremely hard to coordinate. However, if you can find a problem that's of concern to all universally it becomes a rallying point around which you can all move and you begin to develop the pattern of coordination and collaboration. I think it's important to find first those issues that are easy to collaborate on and for which you can get funding.

(*Bauer*) Would something we heard earlier like healthy, happy and nice be something one could rally around?

(*Manoff*) It's a fine term inside, but not for outside. I refuse to develop concepts like that. I'm very serious about sitting down with people. One of the most effective ways to arbitrate debates is to do research. When you walk in to a meeting with a board of trustees or the directors of an agency and you say we've come up with this parenting program that we think is great, and we think it's going to solve the problem, you can be challenged if you have no data. If you go out and do your focus groups, you can say: "This is what the consumers are telling us," and make your point. I'm not just putting emphasis on this kind of research because I thinks it's proper, I don't move without doing it. I have learned a tremendous amount from people to whom eventually we want to address messages.

(*Chamberlin*) Well, let's take the kindergarten example. Suppose your goal is that you want to get kindergartens in all the communities and then you've got to figure out how do it because you can't sell kindergarten as kindergarten because it's not sexy enough. So then you have to figure out some way to sell kindergartens indirectly as something that catches peoples needs or where they're at.

(*Manoff*) Not quite. I'm not saying you have to call it something else because it's not sexy. What I'm saying is really, is it urgent? What is the urgency of having kindergartens?

(*Chamberlin*) The urgency is that 30% of our adolescents are dropping out of high school and we're spending millions of dollars on special education. It's costing us a lot of money and wasting a lot of human potential because there are no really good preschool programs. Kindergarten is the first step and then you need to go back another year.

(*Manoff*) Now who is this good for, the child or for the mother?

(*Chamberlin*) It's good for everybody. It's good for the community. And it's good for the child.

(*Manoff*) My impression is that in terms of urgency it may not be the most urgent thing to impress the funding people in the legislature.

(*Chamberlin*) Yes, but they're all working downstream. They only respond to these problems when they have to do something because there is some kind of crisis. The question is, how to shift them upstream to the area of primary prevention.

(*Manoff*) But if you recast in terms of the need rather than in terms of the strategy . . .

(*Weil*) The point that you're making is that you would go out and find out whether citizens perceive it that way and want kindergartens.

(*Manoff*) And if so, why.

(*Weil*) You've decided that that is what they need for your reasons but I think, if I read you correctly, you would say is that what families of 5 or 6 year olds want in New Hampshire.

(*Chamberlin*) A lot of them do, but the older people who control the legislature say, "Well I didn't go to kindergarten and look at me, I did all right."

(*Manoff*) Well, I would not anticipate what they would do with it until I found out just what the people are saying about it. You get surprising results. For example, in Indonesia. I must tell you that I felt before I came here that the experience in Third World countries might be irrelevant to what I would be hearing here today but I can tell you that there's great similarity. For instance, on breast feeding, we trained Indonesians to go out and do this kind of focus group. It's quick, inexpensive and, extremely valuable. They went out and one of the things they came back with, believe or not, was that in Central Java 95% of the women were feeding their babies from one breast. This is a Moslem society. When this was reported to the officials of the nutrition project none of them had ever heard it before. This was revealed by women talking to each other in these little groups in the villages. The explanation as best we can understand it is, that in some Moslem countries the left hand is for toilet and the right hand is for food. So you can picture the women carrying her baby in her left arm while she's breast feeding on demand as often as 10x a day and she's cooking with her right hand. The reason for this is probably lost to the Indonesian themselves; it's a kind of a social archaeology. Now if you run a breastfeeding promotion campaign to the effect that breast is best, totally oblivious to that, you're going to be relatively ineffective because you're losing a very important part of the milk supply. The most important message in this breast feeding campaign was to figure out some way of breaking this down. This was very difficult because by this time the garment the women were wearing now only opens from one side. Those are the kind of things you find out from focus groups. I think you should take this one to the people and ask them. You walk in with well prepared guidelines and a skillful moderator who introduces subjects and you get them talking about defining their needs. I have found in almost every third world country that people can tell you what they want in terms of needs provided that they're aware that certain health problems exist and that they perceive them as health problems. They may be wrong incidentally in terms of the urgency of those needs but you've got to deal with that knowledge or otherwise it stands as a barrier.

These people who have told you that they're not interested in 'Parenting' but are interested in the exercises classes couldn't be more wrong. That's the problem. The problem isn't selling them 'Parenting' the problem is unselling them on this perception they've got and that takes creative message design for which you do need people who know how to do this. And mind you, even those who know how to do this can't do it every time. That's the part that has to do with creativity, luck, talent and so forth. But the disciplines of inquiry and interpretation are terribly important to planning programs. I will retreat on parenting based on my inadequate knowledge but if you'll give me about two weeks I'll go out and do some focus groups and then I'll either change my mind or be a lot more secure in what I have to say.

(*Chamberlin*) When you set up a focus group, who do you get to participate?

(*Manoff*) You get representatives of the kind of people whom you eventually want to influence. For example, I think somebody very wisely, was it you Mr. Albano, said something about reaching the men. Absolutely right.

Let me go on if I may. I have to read something to you from the Pope. When he came to America, he turned out to be one fine social marketer. I'm quoting from him: "In today's modern world there is always the danger of communication becoming exclusively one way and depriving audiences of the opportunity to participate in the communication process. Should that happen with you, you would no longer be communicators in the full human sense. The people themselves, the general public who you serve should not be excluded in having the opportunity for public dialogue. In order to foster such a dialogue you yourselves as communicators must listen as well as speak. You must seek to communicate with people and not just speak to them. This involves learning about people's needs, being aware of their struggles and presenting all forms of communications with the sensitivity that human dignity requires, your human dignity and theirs. This applies especially to all audio-visual programs." He is dead right. I mean we disagree on many other things but he is dead right about that. We need assurance that our perceptions match with the target audiences perceptions otherwise we get a rejection of what it is.

Quotes from the meeting today, "Women don't know the importance of prenatal care." Another one is, "Low birth weight is good." You put on programs designed to raise the birth weight of babies and unless you're dealing with these misperceptions in their heads, how can you design an appropriate message that's going to get them to seek early prenatal care. If you're going to be successful, you've got to deal with these resistances. Albano said today you need to know adolescent health needs. Well, there's one way to find out, and that is go talk to them. See what they think. Now in all of this mass media is a must. Among health professionals, with whom I've spent the last 20 years of my life, there's a kind of a begrudging respect for the mass media, mostly for the negative impact it has, and yet we have to learn to use it and use it well. There are special ways to use the mass media and not everything that goes on television is necessarily right, as for example, message design. Also, you can't always control the time your message appears unless you're buying it, but at least be aware of the fact that you want to reach target audiences effectively and that there are all kinds of things you can do with the mass media. In Bangladesh, for example, we used soap operas. There are 23,000 family planning workers in Bangladesh. Most of them women, and are absolutely disdained when they get into village communities because the men practically stone them. We wanted to do something about that and we built a soap opera around a women, a heroine. Her name is Lilly because Lilly is a popular name in Bangladesh. What we did was a family planning motivated soap opera. It had nothing to do with family planning except that Lilly, a modern women, chooses a career and what does she choose to be but a family planning worker. The rest of the soap opera, 150 episodes, 15-minutes each episode 3x a week, is about this wonderful person everybody loved in Bangladesh. Even with literacy of under 25%, 10,000 letters arrived at the end of one year. Men wrote in saying I was going to divorce my wife because she's in family planning work and now I understand or family planning workers said they were going to quit until they saw it and so forth. These are things that are possible to do with the appropriate use of mass media depending on what you can afford. At Bangladesh you can make a soap opera from very little money.

Now the mass media is really community based education. And in community wide approaches that's the instrument; absolutely the instrument. There never should be a program in health promotion that doesn't include mass media to the extent that you can get it. Don't be cowed by that television station because you're unfamiliar with it. There are ways to get things on public service time and it's all very helpful. Just remember there's a powerful counter-instruction to everything that you want to do with your program that's going on the air. It's encouraging all the bad habits and building up models that you're trying to knock down. When that happens, you ought to get your community groups to remonstrate with the local television station. When 12 year olds are pictured drinking and smoking, I think you ought to remonstrate. That will get back to the networks if it's a network show. If it's a local syndication, I can tell you that two or three letters coming in to the office of the station managers scares the hell out of them. Tell your community groups to do this when they see modeling of this kind. Call them up. Burn their wires. You'd be surprise how it will have an impact. Become very intolerant of this because one thing like that is so destructive to everything you're trying to do. It's a terribly violent counter-instruction. You've got to use the media and you've got to stop the media from being used for what it's being used for. Just remember that it also reaches powerbrokers. They see things from your program on the air and they know it's important. They're only people and if they see messages on the air that have to do with parenting or whatever they think: 'My God, is this the thing that I almost turned down two months ago, you know I didn't vote for it — Gee, it must be important'. They get the same impact from this that everybody else does.

One last comment. Don't become pawns in cop-out exercises of officials. By that I mean, education is, of all the interventions available to governmental units, probably the least expensive. So that when there is a real problem requiring structural changes, don't be satisfied with just a media campaign. For example, in the developing world, water is a real problem. I tried to promote the boiling of water in one of the Latin American countries and it was an abysmal failure. On evaluation through focus groups it was fairly obvious that the reasons why it was a failure was that all the women had to travel great distances, to find fuel to bring back to boil water. In addition, when they boil water and the air goes out of it, it tastes flat. I swore that I would never again get involved in programs of that kind when in fact this requires a structural improvement. I'll give you another example, breast feeding. You can have all the promotions in the world, but if you still permit the hospitals in your state to separate mother from child and put that baby in the nursery so that she doesn't get the baby to her breast soon enough to establish breast feeding before leaving you are doomed to fail. Women don't have a perceptive experience with breast feeding because there's already two generations of mothers who didn't breast feed. They don't know how to breast feed and there are no support structures. When she comes out of the hospital and she's not breast feeding it's a foregone conclusion that you're doomed to failure. That's a structural problem. Now don't permit your energies to be drained off by applying educational solutions to problems that require structural solutions. Smoking is a problem like that. There is no way in the world that you're going to get to that bottom 30% of the people that are still smoking to stop. They know it's not good for them. They laugh at it unless there is legislation to ban smoking. Let me tell you what happened in New York when there was a threat of such legislation. Smoking cessation course enrollments suddenly shot up like a rocket. The die hards realized the die was cast. They were going to lose their jobs, they were going to get arrested, what ever it was. If this thing came, they better go do something about it. We need multiple strategies and one of those strategies is you've got to have legislation. You've got to have economic investment in changing conditions where there are structural impediments. And, as a matter of fact, I think your kindergarten strategy is one of them. They've got to invest in that and that's not an educational thing. Don't be taken in by that.

We have heard very interesting accounts today. I hope you won't end up thinking that programs like those from Stanford and the Five Community Study and Illinois can only be done in these large communities with large funds. Your speakers told you that they didn't feel that way either and I can assure you it's just not true. You can do it in smaller states with less money. The important thing is think big. Let's start thinking of how programs can be ingeniously designed so that with the available funds you have you can reach more people. The efficient use of the mass media is one of those. Think big, be action oriented and increase coverage relevance, be target audience oriented.

To end I would like to show you a film we made in Bangladesh to illustrate how information from focus groups is used. This is a family planning film for a very traditional Moslem society. That means you never see women on the street and men shop for personal products for their wives. This means that family planning awareness is practically 100% including the rural area. Of course, typically all the women are in favor of it and the men aren't. The Moslem societies are all very, very pro-natalist obviously. The constraints are just that. Now the Bangladesh's did a full research of what I'm talking about and it became quite clear that there was no way to bridge that gap between family planning awareness and practice in one big leap by any kind of an educational campaign. Yet the men definitely had to be the target audience. Family planning programs all around the developing world always address couples. The favorite campaign in India was "The small family is a happy family, 2 or 3 children that's enough," which is about as ineffective as what we say today about "Saying No to Sex." If anybody had ever talked to teenagers, as I have in focus groups, you just know that that's about as ridiculous an approach as possible. Remember what I said about believability, about messages. I mean, every village in Bangladesh knows large families that are happy because they're prosperous and there are some small families that are just miserable including their own probably. These are the kind of messages that are top-down designed because some minister thinks that's the way to do it. In

Bangladesh we knew it was the men and we knew we couldn't get the men to switch over to family planning in one big leap. A recent study showed that 16% of the people were practicing family planning but of the 16% only 6% were using modern methods. In other words, most were using the rhythm method. It was fairly obvious that family planning practice was still at its beginning after years and years of input. We decided to do a creative interpretation of the conversations we heard in our focus groups which we had recorded in Bengale or some local language and had translated for us. We decided that our objective was going to be very simple. The most effective change agent, to change a man's mind, was his wife. We needed to get him to talk to his wife about family planning. You have to understand that the women in Bangladesh quotes, "The obedient wife." That's the standard except middle class women in the city. Certainly a rural wife, would never initiate this discussion with her husband. If we could get husbands to initiate conversation with their wives and get them talking, we were convinced, on the basis of what we found out from those who were practicing contraception, that their attitudes would eventually be influenced favorably. What you're going to see here are some short messages that were designed in the most difficult situations, with the most difficult of subjects — family planning in a Moslem society. It may surprise you that material like this would appear on television, cinema, and also on radio but it does.

There are five messages but I won't play them all because they all follow the same format. Clearly, innovative approaches are needed to create greater demand for contraceptives and to motivate Bangladesh's to use them. What stood in the way? The main thing was the men. Though approving family planning in principle, they are less disposed to practice it with modern methods. Not so with women. The family decisions are a male preserve. Rigorous social marketing research leaves no doubt about this — the Bangladesh male had to be the primary target but the research warned he is a prisoner behind mental barriers, such as fear of negative health effects, ignorance of contraceptive options, and cultural impositions about discussing family planning with his wife. An effective message must pierce each resistance point and demolish it.

Film #1 quoted in English: A wise men of the village is saying, "In my village I am looked upon as a wise man but I have discovered even I can be a fool. I have learned from my wife that there is more to being a good father than being father to a lot of children." She came to me one day and said, "You know how to help people with their problems, but who will help with yours?" "What problems," he asks. "Why do you father more children than you can feed, clothe and educate," she asks. "What could I say," he asks. "I knew about family planning. Even I like a fool had listened to the ignorant tales spread by ignorant people but today I am wiser. I have found out the truth about safe contraceptives. Now we use one of them." "It was a wise man's decision," says his wife. "You did the right thing. I was a fool" he admits "but now I am a wise man. Be a wise man. Do the right thing. Use family planning the wise man's way."

#2) This is a proud man who speaks. He says, "I am a father. I know how to grow plants, good land, the right seed, and provide enough room for each plant. I considered myself a wise man until one day when my wife said to me, "You are not only a farmer you are also a father of children. As a farmer takes care of his crops in the field, so a father takes care of his family. You do not grow more plants than the land can hold. Why do you father more children than we have room in the house, than we have food, than we have money to educate. Dear husband, we are having too many children and it has made me weak and sick. What about the family planning I hear about on the radio." He said, "I hear family planning is not safe." But his wife had another idea. "Why not ask a teacher." He did but when he repeated the rumor, the teacher said, "Do not believe the ignorant tales by ignorant people." He then told the farmer about the many safe ways and made him realize how wrong he had been and the farmer later talked with his wife about this and together they decided to adopt family planning. Now she is happy. She says, "Now I am well and strong. Our children grow bigger and healthier. My husband is a good farmer and a good father. He is a wise man." "No," says the farmer. "I have been a fool, now I am a wise man. Be a wise man. Do the right thing. Use family planning the wise man's way."

(*Manoff*) Some of those key phrases: "Ignorant tales, ignorant people," the "right thing," the "wise man" are taken right out of the mouths of the focus groups. This was a subject that was very difficult to talk to people directly about so we used a photo projective technique. We took photos of various Bangladesh people, men and women. We laid the photos out and we asked the groups to sort out the pictures into two groups, those who practiced family planning and those who didn't, and then we began to focus on certain of the pictures and asked questions. Well, if that's the case, why do you think this person did it. So instead of talking about themselves, they're really projecting their own thoughts onto other people. Why would this man practice family planning: Well, he's obviously a rich man and he's smart and wise and so forth. We got this language and we decided it was very usable and we made it into a refrain which is now heard on the streets of Dakar I am told.

After a year, a research organization in Dakar showed an increase of 20% of the men who were discussing family planning with their wives, mostly in the cities. Now that meant, if the figure is correct, that 8 million husbands were now open with discussing family planning with their wives. I always am suspicious of research either way. If the results are bad, I think probably that they should be better. If they are too good, then I get a little bit jittery, I don't want to be attacked when they're presented. So I will take that 8 million figure and I'll chop it down to 4 million.

In terms of selling programs, I don't see how I can sell primary health care in the developing world by saying, "you come and we'll take care of all your health needs." In the developing world, in villages and rural areas you go to a doctor if one is available or take a trip to a doctor if you're near death. You carry a baby that's practically beyond recovery to a doctor. But you know these aren't real appeals. On the other hand, if you can identify a disease that a baby can get from a cause that they understand, you can focus them on that concern. But even then it's hard to motivate. It's hard to make people change their patterns. You get a memo in the office saying this procedure that we've been following for 14 years is now going to be changed effective Monday. You go out of your mind, because you're a creature of habit and you don't like this. On the other hand, if you've got this bulletin that said: "If you will change this behavior on Monday, you will get that raise you haven't had in two years," well I've gotten to you. I really know what you've been looking for and I've made it possible for you. That's what I'm talking about. I'm being a little simplistic but you get my point.

(*Mitchell*) You're not necessarily saying that we need to change the program on parenting so much as to be . . .

(*Manoff*) That's correct. I don't see anything wrong with the program. What I'm trying to say is that it's how you present it. For example, calling your program "Parents Too Soon." Boy, that hit. If they had called it something like 'Ethical Living for Young People' they would all stay home, forget it. So it is important how you present programs. Very often, in terms of getting your funding and making your impact, presentation is more important than the substance because the substance, as in the case of parenting, can be an abstraction until they're brought to it. Bringing them to it, in my experience, is usually by emphasizing some currently urgent single purpose. Every primary care program is made up of elements. In the past, they've been vertical programs by themselves. We've now gotten this primary care philosophy 10 years after Alma Ata and it's dead right. These vertical programs don't do very well on their own by themselves. They should be combined and you get more of a uniformity. It's very hard to sell family planning, for example, to a family in the Third World where 3 out of 6 children are dead by the time they are 5 years of age. But if you can do this in connection with health services, and you talk about that in your plan, you've got a chance. You do them vertically and they impinge on each other and they're best put together but that doesn't mean that you can't present them separately.

End of First Day's Session

Community Wide Approaches to Preventing Preterm Birth

Presentation by Dr. Emile Papiernik

Dr. Chamberlin: This morning we move from the developing to the developed world. My sequence of coming across what Dr. Papiernik is doing was that I first heard Dr. Farquhar from Stanford talk about community-wide approaches to preventing cardiovascular disease at a public health meeting in Arizona three or four years ago. I thought, wow, this group has developed all the technology that you need for a community wide approach, and, if you can change health habits related to cardiovascular disease, why can't you change health habits related to pregnancy outcome with the same kind of approach. Then a year or so ago, I heard Dr. Papiernik speak and I was amazed to find out he was already doing this and, in fact, had been using this kind of population approach for 10 years. Furthermore, he had some documentation of its effectiveness in preventing preterm birth.

Dr. Papiernik's official title is Professor and Chief of Service of Obstetrics and Gynecology at the Hospital of Paris. He's conducted a number of studies on community-wide approaches to preventing preterm labor in France and also in Martinique. It is with much pleasure that I turn the podium over to Dr. Papiernik.

Dr. Papiernik: Thank you for inviting me. I think I will address two points. You can sell something if you have something good to sell. If you don't have a good idea and a measurable effect, then your selling might be good but the results will be bad. I had a chance to sell to the French government a policy when it was extremely interested in reducing handicaps coming from a perinatal origin. This was in the early 70's and came after a press campaign done by a leading pediatrician in our country, Alexandre Minkowski, who said that a lot of babies are coming to an intensive care unit who should not be there. It could have been prevented. He also said that having anoxia during labor is avoidable and being born too soon should be avoidable. This was a very clear message that was related to the goal of preventing the crippled child. Pompidou was President and he was the director of the Foundation for Crippled Children. The Minister of Health, Boulin, a very good man, had a subministry related to prevention of handicap, headed by Mademoiselle Dienesh. They got the press campaign spot done by the pediatrician, and said: "We will do something," but they didn't know what to do. They had to prepare a policy with a cost effective technology — what can be done, at what price, and with what result. I was invited as a consultant because I had published a paper in 1969 on Prevention of Preterm Delivery With a Risk Assessment, and I developed a quantitative measure of risk. I was invited and it turned out that no other obstetrician was really interested in a public health approach to prevention so that after a few meetings I was the only one that remained on the board. This gave me the chance, at a very young age, to propose a national policy. I proposed to apply all the well established things like the prenatal care system in Sweden and the new technology to monitor anoxia during labor. I also put in my techniques for the prevention of preterm delivery which were not proven at this time but became accepted as a national policy. I asked, in the implementation of the program in 1970, that money should be given to our National Institute of Health for evaluation. That's it. I'll show you the principles. I'll show you the national results. I'll also show you the results of the Haguenau Study, which is what happened at a district hospital as a result of our national policy. We picked an area far from Paris where there was one hospital serving one community. We have been following this population with computerized data since 1971 and this includes twenty thousand women.

(*Chamberlin*) You started your program from the top down?

(*Papiernik*) I published a paper in '69 which was based on my personal experience. I had met the pediatrician, Dr. Minkowski, in the elevator because we were working in the same place and he asked me: "Have you ever seen a preterm baby." I was a chief resident in obstetrics at that time and I had to answer no because the midwive's were delivering the preterm babies because it was not a surgical problem! I had never seen one even though I had 7 or 8 years of training in obstetrics. So with him I discovered that to be born too early was not to put the baby in a box and take it out two months later, this was not true. The baby was suffering. The baby was at risk of dying and the baby was at higher risk of being crippled only because he was born several weeks too early. This was in 1967. Then I did something like Richard Manoff talked about yesterday. I sat near the bedside of each of the women who had a preterm delivery and asked her questions about what happened. From this I progressively discovered some of the ideas which I put into a set of hypotheses. By 1970 I had the personal experience of three years of asking questions and had developed some ideas about the epidemiology of preterm birth and what might be done to prevent them. I also had at that time started a demonstration study in the Port Royal Hospital in Paris where I was working. This was on a small number of women because all the people there did not accept my ideas. I was unable to get my ideas accepted in the hospital in which I was employed, so I was obliged to go to the national level! This is the real story as funny as it seems. So this is what we have sold to the politicians, less handicap. They were not interested by death. Prevention of preterm delivery was the basic message. I did, like Manoff suggested, use very simple messages that were very, very short with one idea.

I thought that risk scoring was possible based on past history, lifestyle, and the result of the obstetrical examination. If you look in the literature, there are a lot of predictors of preterm deliveries: low-social status, young age, multiparity, and previous preterm birth or bleeding during pregnancy. The difficulty with these predictors are that you cannot change them during pregnancy. If this women comes in and she's 16, then she's 16. So what can you do. It's important to know but completely useless. I proposed new predictors related to lifestyle and to work habits. This is what I had discovered by asking questions: I found that more than 10% of the births of nurses in the neonatal unit were preterm deliveries. The nurses in the orthopedic unit in my hospital had 15% preterm deliveries and this was not written in the textbooks. Also, I discovered that those women had felt something, abnormal uterine contractions, that they were able to describe after birth. Something went abnormal several days or several weeks before the preterm delivery. I discovered by myself that the physical examination of these women was indicating a risk if I measured shortening of the cervix. This is what happens normally in the days or weeks just before term delivery, a progressive shortening and opening of the uterine cervix. If it happens at 24, 25, or 28 weeks, it goes to predict a preterm delivery. These are the tools I use, very simple. Progressively I come in with better descriptions of the risk conditions: standing up for long hours, lifting, and moving. Some risk professions are quite easy to describe. For instance, the risk of preterm births for hard professional work as defined above is about twice that of other occupations. It's not a very strong predictor (7% versus 4%). The sensitivity and specificity are not as good as we would like; meaning, that you have to adapt the preventive proposals to the fact that the sensitivity and specificity are low. This means, that you cannot propose a hard intervention (such as drugs with toxic side effects), you have to propose a soft intervention like change in lifestyle. For instance in the Paris area, a long commuting time is a real problem. If you commute more than two hours, then the rate of preterm deliveries goes up. But for some women it was only a fast walk which was triggering uterine contractions. You have only to ask her what are the specifics of her daily life that are inducing contractions. For some, sexual intercourse but this is rarely the case. So the obstetrician can discover something during prenatal visits if he does them. I don't know why in the U.K. and in the U.S. there is no habit of doing a vaginal examination during pregnancy as is the habit in France, Germany, and in all continental Europe. I don't know from where these difference in habits come so this point is a difficult one in your country. But I propose that a vaginal exam should be considered because it helps determine who is at risk.

What is the basis for prevention? It's to avoid uterine contractions. For those women defined as highest risk it's by the reduction of physical work, by modification in lifestyle, and by reimbursed paid work leave where needed. This was possible in our system because we already had the sickness work leave. My specific input was to transform sickness work leave from being related only to sickness to be accepted as a preventive tool for preterm pregnancy. This was through very sharp negotiations with our Social Security system. They didn't like it but when I said I would hold personally responsible for the preterm delivery any doctor that refused to grant work leave to these women, I broke through this resistance. You also have to have a good prenatal care program and ask questions to get information on lifestyle and work habits.

This is a second problem in your country when the mean duration time of a prenatal visit is 5 minutes. You'll have to find a way to convince obstetricians to spend 20 minutes, and this is a real resistance in your country, but you can ask the midwives or nurse practitioners to do this. They are very happy to do that and they can do that very well as we have demonstrated in Martinique for instance. You have to tell the women that she's at risk — why, how. She has to understand what is happening and then decide what can be her specific preventive role and she likes that. Each woman should be able to recognize uterine contractions. This idea has been used in your country through a device sold by a commercial company but it costs $75 a day. I think that every woman can save that money and do that by herself and it works very well. Education of the patient is one of the basic components. Education of the public includes men, because they are resisting the fact that their wife should do less at home or their employee should have work leave. But we were successful in convincing many employers to give up ½ an hour in the morning and a ½ hour in the evening to allow pregnant women to travel out of the rush hours. You have also to educate care teams applying those ideas. For instance, in your country where controlled trials have been done in several sights, I am concerned that the teams applying those ideas have not had enough training.

The women accept the ideas but it's not always so easy. The social marketing doesn't work in the same time for all women. The very rich and well informed women accept that immediately but for the others it takes longer. For middle class women it takes about four years and for lower class women four years more. So you have to take the time. It's a major problem. It will not be solved in one or two years. For women at risk you can propose rest, not bed rest, and home visits by a mid wife. Home visits are very important for the psychological support and conveying of information. For this we have done a controlled trial showing that for the very low educated women, who are at high risk for social reasons, this is one of the best ways to spread the information. This is because they don't read the pamphlets and don't understand the radio and TV ads. They have to have a personal relationship with a knowing woman, taking one hour at a time to look on all the details and this is very important. We also convinced the local authorities that they should participate in the prevention by providing domestic help to pregnant women on medical advice. My talk is now up to where medication is needed, and I'll stop there because the rest is not primary prevention. One of the items I have been following in the Haguenau Study is how long it takes women to come in the first trimester to be followed by the obstetrical team instead of by their general practitioners who were not using this approach.

Table 1. Haguenau Study

Variation in Onset of Prenatal Care and Percentages of Women Seen by the Obstetrical Team Over Time

	1971–74	1975–78	1979–82
Seen first trimester	24.2	38.2	47.5
Never seen by team	37.0	17.4	6.5

p<0.001

You see that it takes years and years, and some women are never seen by our obstetrical team. This was 15 years ago when we began and would not be as difficult today. Table II shows how this relates to education in Haguenau.

Table 2: Haguenau Study

Participation in Proposed Care System (First Trimester Visit) by Years of Maternal Education

	1971-74	1975-78	1979-82	p value
≤9	17.7	28.5	38.6	0.001
10-12	30.0	49.5	61.7	0.001
13 +	47.5	65.5	69.6	0.001

Participation in the first trimester by women with more than 13 years of education was good almost immediately. For those with 10 to 12 years, it took them 4 more years to reach the same level of participation. It took eight years for the least educated women to reach anywhere near that level of participation in the proposed care. So be careful and don't ask for grants for two years. You'll not solve the problem and all the publications in this country where the results are given in one or two years are really open to severe criticism.

I'll show you the National evaluation done in France. I'm asked what does this study involve and I say, "Oh, not more than 55 million people, 700 to 800 housand births per year, and 12 years of intervention." It's not a controlled trial because the politicians didn't accept that but we have controls in Germany and in the U.K. and the United States where no reduction in preterm delivery has been observed during the same years, even though all the pregnant women have access to the same technologies. So it's not a controlled study but we have an important data set to compare with millions of people and millions of births. These results are published in French and will be published in English by the March of Dimes in 1988 or '89.

We have three representative samples of births by our National Institute of Health. There are 11,000 in the first study and about 5,000 in the two other samples. First, we looked at the social and demographic characteristics of the population over time to see if any shifts in composition could explain the positive effects that we have observed. The proportion of women less than twenty years of age having a birth declined from 9% to 6%. The proportion of women more than 40 years declined, and parity declined, but when we controlled for these changes in our analysis, the results were not changed. The educational level of women improved during this time also but controlling for this did not effect the results either. We looked at the outcome of the previous pregnancies and found out that the rate of prior stillbirths did not decline but the rate of prior births of less than 2500 grams declined. The rate of abortion was higher because abortion was legalized in 1975 during the study. So all these factors should be controlled for in the analysis and they were.

We looked at the modification of the care system. For instance, in the national policy, we had proposed the disappearance of maternities with less than 15 beds. We were somewhat successful in that, but not completely. The use of electronic fetal monitoring went up from 6% to 70% over this 10 year period. Cesarean sections increased from 6% to 11%. These changes were included in our analyses and altered the findings only slightly.

In the National Study we looked at how successful we were in implementing our prenatal care policy over the country as a whole.

Table 3: French National Study

Evolution of Prenatal Care Habits over Time: (Total Sample)

Number of visits	1972	1976	1981
<4	15.3	10.6	3.9
4-6	62.5	55.5	41.2
7+	22.2	33.9	54.9
p<0.001			

INSERM U. 149/1983

More than half of the population at the end instead of only 22% at the beginning had 7 visits during pregnancy. An increasing number of visits were made to the obstetrical teams.

In the Haguenau Study, we looked at the health related behavior of specific risk groups and this is one of the outcomes of our study that is very important. Specific risk groups, behaved exactly as the general population. They didn't accept being labelled "at risk." This means to us you cannot modify the behavior of the women at risk if you don't modify the behavior of the total population of pregnant women. This is one of the major results of our study. I'm convinced that we have figures to show that only a community wide approach can modify the behavior of the pregnant women and not an "at risk" only approach. Because of this, I think the strategy that has been chosen in the United States by the March of Dimes that focuses only on the high risk women is an impossible task. We have a precise demonstration that you cannot modify the behavior of a small group inside the population. It's like jogging. All the people jog, the at risk and the not at risk, and then you modify the result in cardiovascular disease but if you ask only those people with high cholesterol to jog, they will not do it. For pregnant women, it's exactly the same.

Table 4: Haguenau Study

Proportion of Women Seen at the Prenatal Clinic During the First Trimester According to Obstetrical History

	1971-1974		1975-1978		1979-1982	
	N	%	N	%	N	%
Nulliparous	2144	22.0	2390	37.7	2609	47.0
Multiparous without previous stillbirth or preterm birth	2507	25.4	2323	38.2	3034	47.8
Multiparous with previous preterm birth	329	23.1	229	40.2	242	47.5
Multiparous with previous stillbirth	29	24.1	23	39.1	41	46.3
Multiparous with previous stillbirth and preterm birth	35	31.4	31	54.8	38	60.5

N = Total number of women in the category

From Table 4 it can be seen that women with a previous history of giving birth to either a low weight baby or stillborn child behave exactly like those with a normal birth history in terms of when they start prenatal care. It is only when they had experienced both those events that they came in to care earlier.

Similarly, it was found that women below twenty, who generally behave very badly, came in earlier for care and were more likely to see an obstetrical team as these behaviors increased for the population in general and increased for their older sisters in particular. Even the prenatal care behavior of immigrants, many of whom could not read or speak French, mirrored that of the general population so we were able to get the message through in this way. We emphasized care by the obstetrical team because the general practitioners did not readily adapt these ideas into their care patterns.

Table 5 shows how the care seeking behavior of women with a previous history of stillbirth or low-weight baby changed as the prenatal care program reached the general population.

Table 5: French National Study

Changes in Care-Seeking Behavior of Women with a History of Stillbirth or Low-Weight Birth

	1972	1976	1981	p value
4 prenatal visits	50.0	71.8	90.3	0.001
Saw G.P. only	25.2	11.7	3.0	0.001

Table 6 shows changes in the frequency of various risk factors in the general population over time.

Table 6: French National Study

Changes in Population Risk Factors Related to Pregnancy Outcome over Time

	1972	1976	1981	p value
High blood pressure in 3rd trimester		7.1	8.3	0.001
Rh ISO immunization	2.6	2.0	1.2	0.001
Bleeding 3rd trimester	2.3	1.8	1.9	0.001
Suspected interuterine growth retardation		4.8	5.8	0.05

RUMEAU ROUQUETTE – Naître en France, 1985

The Rh factor, for instance, went down not because of our policy but something completely different coming into the field of new technology, but bleeding in the third trimester was reduced as a risk factor in the population. I will come back to that later. We suspected intrauterine growth retardation much more than we did before because we were more aware of it.

Table 7 shows changes in the working conditions of women during pregnancy. We asked the women about their working conditions and the very tiring type of work was less. Working with standing up for long hours, which was defined as more than three hours per day, was also somewhat less but did not disappear.

Table 7: French National Study

Changes Reported in Working Conditions During Pregnancy

	1972	1976	1981	p value
Third trimester				
Very tiring	20.7	18.1	15.0	
Tiring	37.7	45.8	49.3	
Easy	41.6	36.1	35.7	0.001
Standing up for long hours	47.5	43.9	37.3	0.001

RUMEAU ROUQUETTE – Naitre en France, 1985.

We said that work leave should be extended from the previous work leave which was six weeks before the expected date of delivery. We were successful in applying that idea to the general population in that about 40% of all pregnant women took 7 or more weeks leave in 1981 compared to 16% in 1976. This was a costly measure but it was demanded and accepted by the population of women. They were willing to protect their pregnancy instead of looking for job security at work.

Table 8: French National Study

Percent of Pregnant Women Who Took Different Durations of Prenatal Work Leave at Two Time Periods

	1976	1981	p value
1- 6 weeks	84.0%	57.8%	0.001
7-8 weeks	12.9	29.8	0.001
9+ weeks	3.1	12.4	0.001

RUMEAU ROUQUETTE – Naître en France, 1985.

We have been collecting the amount of sickness work leave in the first, second and third trimester to measure exactly the amount of what we added to the package. Also, we looked at hospital stay for any reasons during the pregnancy, which is also a costly measure, and it came up also from about 8% in 1972 to 18% in 1981.

Table 9: French National Study

Changes of Percentage Distribution of Preterm Births over Time

	1972		1976		1981	
	N = 11,254		N = 4685		N = 5508	
	N	%	N	%	N	%
< 34 weeks	242	2.4	75	1.7	59	1.2
34-36 weeks	578	5.8	220	5.1	227	4.4
< 37 weeks	820	8.2	295	7.7	286	5.6
< 37 weeks, excluding twins, stillbirths and major malformations	716	7.4	249	6.0	245	5.0

p value <0.001

Pregnancy Outcome. As can be seen in Table 9, we were successful in modifying the distribution of births by gestational age.

The group at very high risk with gestational age less than 34 weeks was reduced from 2.4% to 1.2% (p .001). This is the major impact of our policy. These are the costly preterms. These are the preterms at risk for death and intracerebral bleeding. We modified slightly the numbers at 34 to 36 weeks but not a lot. A similar result was found in the Haguenau Study where births of less than 33 weeks were reduced from 1.5% to 0.5% (p .001).

Since gestational age is somewhat difficult to measure we used birth weight as a control. As can be seen in Table 10, we found the very high risk group from 500 to 1500 grams was reduced by half from .8% to .4%. And this makes a difference. At .4% we are reaching exactly the same results as in Sweden.

Table 10: French National Study

Changes in Percentage Distribution of all Births by Birth-Weight over Time, Including Still Births and Twins

	Percent of All Births			
	1972	1976	1981	p value
Birth weight in grams				
500–1499	0.8	0.7	0.4	0.001
1500–1999	1.2	0.9	1.0	
2000–2499	4.2	2.9	3.8	
2500–2999	19.1	17.9	18.0	
3000 or more	74.7	75.6	76.8	
Unknown	1.5	0.6	0.5	

RUMEAU ROUQUETTE– Naître en France, 1985

Perinatal deaths were also reduced. If we look at birth weight and gestation duration for all babies stillborn or dying in the neonatal period, you see in Table 11 that in 1972, the less than 2000 gram births and the less or equal to 32 weeks gestation births make up about half of the perinatal deaths (55% and 47%). In 1981, these were reduced to only 30% and 24%, meaning, that the contribution of preterm delivery to perinatal deaths was tremendously reduced.

Table 11: French National Study

Birth Weight and Gestation Duration of Still Births or Neonatal Deaths (%)

	1972	1976	1981
Birth weight			
< 2000 grams	55%	33%	30%
2000–2499 grams	12	22	0
≥ 2500 grams	33	45	70
Gestational age			
≤32 weeks	47	29	24
33–36 weeks	18	17	4
≥37 weeks	35	54	72

RUMEAU ROUQUETTE – Naitre en France, 1985.

If we turn to the Haguenau Study where we have followed 16,000 women from '71 to '82 we find exactly the same result. Births under 1500 grams were reduced from 0.9% to 0.4% and preterm births less than 33 weeks gestation from 1.5% to 0.5%.

Table 12: Haguenau Study

Changes in Distribution by Gestational Age of Live Births over Time

	1971-74		1975-78		1979-82		
	5548		4787		5811		
	N	%	N	%	N	%	p value
Gestational age							
Less than 33 weeks	81	1.5	51	1.0	29	0.5	0.001
33-34 weeks	59	1.1	39	0.8	39	0.7	0.05
35-36 weeks	159	2.9	102	2.1	142	2.4	n.s.
Less than 37 weeks	299	5.4	192	4.0	210	3.6	0.001

Table 13: Haguenau Study

Changes in Distribution by Birth Weight of All Births Over Time

	1971-1974		1975-1978		1979-1982		
	N=5835		N=4991		N=5963		
	N	%	N	%	N	%	p value
Birth weight							
<1500 grams	53	0.9	38	0.8	26	0.4	0.01
1500-1999 grams	60	1.0	50	1.0	45	0.7	n.s.
2000-2499 grams	189	3.2	129	2.6	178	2.9	n.s.
<2500 grams	302	5.2	217	4.4	248	4.2	0.01
<2500 grams, 37+ weeks	110	2.0	80	1.7	112	1.9	n.s.
<2500 grams, <37 weeks	173	3.1	124	2.6	129	2.2	0.01

These changes in care and reductions in low weight births resulted in significantly fewer transfers to neonatal intensive care units.

Table 14: Haguenau Study

Changes in Numbers of Transfers Neonatal Intensive Care Unit over Time

	1971-74		1975-78		1979-82	
Number of Live Births	5760		4948		5917	
Gestational Age of Transfered Babies	Number ( ) and Rate per Thousand for Babies Transferred at Different Gestational Ages					
≤ 32 weeks	(27)	4.7	(23)	4.6	(11)	1.9
33–36 weeks	(17)	3.0	(17)	3.4	(19)	3.2
≥ 37 weeks	(58)	10.1	(29)	5.9	(22)	3.7
Total	(102)	17.7	(69)	13.9	(52)	8.8

We looked at this in terms of the savings in days of need for intensive care and pediatric care out of the maternity unit per one thousand births. The days in neonatal intensive care was reduced from 425 to 182 days and care in the pediatric unit from 437 to 223 days. This makes an enormous difference in cost.

Table 15: Haguenau Study

Reduction in Intensive Care and Hospital Bed Days per One Thousand Live Births

Neonatal Hospital Days After Transfers and After Standardization for Duration of Care by the 1979–1982 Period. For 1000 Single Live Births and for Gestational Age ≤35 Weeks and Excluding Malformations

	1971–74	1975–78	1979–82
Days in neonatal intensive care	425	296	182
Days in pediatric department	437	320	223

We have looked on neonatal mortality which was reduced from 8 per thousand in the beginning to 2.7 per thousand in the later period. With standardization we tried to measure what portion of that was caused by better babies or by better care.

Table 16: Haguenau Study

Effects of Reduction of Preterm Births on Neonatal Mortality After Standardization

	1971–74	1975–78	1979–82
Neonatal deaths per thousand live births	8.5 (47/5548)	6.3 (30/4787)	2.7 (16/5808)
Rates standardized for gestational age distribution 1971–74 and confidence interval	8.5	7.2 4.8–9.6	5.3 3–7.6

This Table shows that if the distribution by birth weight and gestation had not changed we would have had a reduction from 8.5 to 5.3 based on improvements in care alone. The reduction in preterm births resulted in a further reduction from 5.3 to 2.7 deaths per thousand.

In terms of preventing handicaps, we found over time that the number of abnormal neurological signs observed in the neonatal period per thousand births was reduced.

Table 17: Haguenau Study

Changes In Abnormal Neurological Signs Observed in the Neonatal Period

	1971–74	1975–78	1979–82	p value
Preterm <37 weeks	11.0% (33/299)	5.7% (11/192)	1.0% (2/210)	0.001
Term 37+	1.1% (59/5249)	0.7% (30/4595)	0.1% (8/5601)	0.001

The reasons here included: better obstetrical care, less anoxia, and less preterm deliveries. We do not at this point have the figures to show you that we were successful in reducing the actual number of handicapped children. What we have measured is those two points. We have less preterm births and we have less abnormal neurologic signs observed in the neonatal period so that we can say we have reduced the risk for a later handicap.

How does prevention work. It works by reducing the rates of risk factors in the general population.

Table 18: Haguenau Study

Changes in Rates of High Risk Predictors for Preterm Babies over Time

	1971-74	1975-78	1979-82	p value
Previous preterm	12.5	10.0	8.3	0.001
<20 years of age	17.4	17.1	14.1	0.001
>35 years of age	8.4	4.0	3.1	0.001
Bleeding in trimester:				
Second	7.1	3.3	2.8	0.001
Third	3.9	1.7	1.6	0.001

The number of women with a previous preterm birth was reduced in the population as a result of our policy, so that for the next pregnancy she was less at risk. The number of women of less than 20 years and those more than 35 were reduced by other means. We convinced them not to become pregnant. Bleeding in the 2nd or 3rd trimester, which is a predictor for a bad outcome, was reduced in the observation. These risk factors were reduced both in the Haguenau Study as well as in the National Study.

So what does it cost? What are the advantages of this policy? There is a cost obviously. Work leave is a major cost. What we have calculated is that 2/3 of this cost has been compensated by the reduction in cost in neonatal care. Meaning, that the real investment for long-term is only 1/3 of the Franks involved.

(*Chamberlin*) These are both paid for by the government? They would pay both for work leave and neonatal care?

(*Papiernik*) Yes, but they are not paid by the same administration. This is one of the problems. One says, I pay for that and the second says, I save for that but they have to speak together sometimes.

(*Chamberlin*) But it's the government that pays both of them?

(*Papiernik*) The Social Security system which is a so called private institution.

We calculated the cost of years of quality of life without handicap. If you gain one life at birth, you gain an expectation of 75 years. If you do an intervention for a 75-year-old man, the best you can gain is one year. So the cost of intervention, even if it's high, may be spread out over 75 years of life expectancy so that it comes to a very low figure compared to, for instance, the cost of a cholesterol lowering medication where one year of life saved costs from $100,000 in the best group 35 to 39 years to $1,000,000 for the group of 60 to 65 years and this will become an accepted policy in your country as well as many others. You will pay $100,000 for one year saved by this policy and with prevention of preterm delivery, the real cost is $1,000 not $100,000.

(*Chamberlin*) Dr. Papiernik, one of the things that I noted in your articles, you didn't mention the importance of having the mid wife go out into the community to follow the people that are hard to reach and it seems to me that's an essential component of all of this.

(*Papiernik*) For a small number of women the only way to reach them is through home going midwives.

(*Albano*) What is the percentage of two income households?

(*Papiernik*) More than 60 percent of women are working.

(*Albano*) Were there any national policies in regards to leave for men?

(*Papiernik*) Three days. Not like in Sweden.

(*Berry*) What's your percent of single head of households in France?

(*Papiernik*) It's really difficult now to measure because for fiscal reasons the young couples don't marry anymore, for instance, in my department 40% of births are to single women so called but they are not living alone. The baby takes the name of his father which makes it difficult to determine the exact incidence.

(*Weiss*) One of the things that interested me is that you've tried to change what we call parental leave policy. As I understand it, our legislation, which hasn't passed yet, is primarily oriented towards post-birth leave and we don't have a lot of public education around the need for prenatal leave.

(*Papiernik*) Yes, one reason for your post-partum leave policy is to increase breast feeding and this was really proposed by the pediatric community, thinking that life begins at birth which is not true. Life begins earlier. But we know that and the women know that, but the obstetrical community was not interested in going in. It was the same situation in France. But in France prenatal work leave was proposed by a pediatrician in 1933, Robert Debre. It was based on an international study by one of the leading pediatricians in Europe, Dr. Yulpo, who found preterm delivery was related to hard work. They collected information all over Europe by the League of Nations Office of Hygiene and the book is published in French. However, you may remember that the American doctors were not part of it because America was not part of the League of Nations at that time. I think that it's an historically interesting point that the idea of proposing work leave for pregnant women didn't pass the Atlantic because of your decision not to join the League of Nations. All of Europe has done it before or after the second World War. It was an international European policy.

(*Weiss*) Is there also post-partum leave?

(*Papiernik*) Yes, eight weeks.

(*Bauer*) Your data is very descriptive of what you observed. Are you willing to go beyond that in terms of hypothesizing what the mechanism behind it was? Specifically, I've read materials that suggest that both reduction of stress and the provision of social support reduces preterm labor and your intervention, as I see it, provided both of those things. Do you have theories about that?

(*Papiernik*) No. You have to put it in a hypothesis and test it. First, we have to show the prevention of preterm delivery is possible because some very bad studies in your country have said it's not possible. In Philadelphia, with inner city Blacks, a preventive program was not effective in a two year study. If you take men of 60 years of age with a blood pressure of 200/120 and ask him to run, then you'll find you can't prevent cardiovascular disease, in fact, you'll have more. I think that this is a very important point. It's impossible to make prevention work if you address a very high risk group. *Prevention works in the middle risk group by keeping them from becoming high risk. It's the same for all types of preventative policies.*

(*Bauer*) People will, in making policy, be inclined to make decisions over what they think reduced preterm births. I could picture one policy maker saying that we should give all women a leave from work in the last two months of pregnancy and that will reduce our rate of prematurity. I can see another policy maker saying that what we really should do is get all women into a system of care, and we should be doing home visits with midwives and provide all the support and that will reduce preterm births, and then somebody else might say we should do both.

(*Papiernik*) You're asking good questions. What should you do? With the risk evaluation system you can adapt your policy to the needs. However, what happens, as for instance in France, is if you add more work leave to 20% of the working population, then other women ask for more for themselves because they feel that it's a comfort. It makes their life better and the relationship with the baby better. So it was accepted in France to extend the work leave four weeks more only by prescription. So the mean work leave prior to birth is now 10 weeks, but it's not evenly distributed. It's related to the risk. If you cannot afford a lot, you have to choose those women for whom it will be effective for this type of intervention and another type of intervention could be effective for another type of women.

(*Weiss*) As I understand your program, what you did was: by public education you changed the employment leave policy, you tried to change obstetrical practice, you did home visits, and made some kind of provision for somebody who would help in the home for those people who needed it, and then you tried to change family behavior by trying to get the husband to be less demanding of the wife . . .

(*Papiernik*) Of helping even sometimes.

(*Weiss*) Exactly. So what you're talking about is a comprehensive policy which could be fine tuned with your risk assessment.

(*Papiernik*) Yes.

(*Weiss*) In other words, your home visits might be targeted to the at risk people.

(*Papiernik*) Probably home visits could be targeted to only those women with very low access to information.

(*Weiss*) Right. So it's comprehensive but with the possibility of fine tuning it depending upon risk categorization. So really the answer to your question is, that you can't do one piece of this and expect the same results.

(*Chamberlin*) That's the key.

(*Papiernik*) Yes. It's a very important statement. It's a policy, it's not a single treatment.

(*Chamberlin*) What is fascinating to me is what I heard about this approach in this country came through Dr. Creasy who translated it into a high tech approach by bringing in these women and giving them a tocolytic drug to prevent preterm labor. Now it's also apparently been translated into a high risk only approach by the March of Dimes. Actually, our culture missed the whole point.

(*Papiernik*) You didn't miss all points. You didn't miss technological points and the money making system.

(*Jackson*) I just want to second that point because often times when we present the Heart Disease Prevention Program and all the pieces that we do, we're often asked the question, "Well, which pieces should we use? Which are most effective?" And the idea is that there's something about the comprehensiveness of it. So that when people go out to eat they see something, when their kids come home from school they're getting something, when they go to work they're getting something, and also when they visit their physician, so that it really is the wholeness of it that is, I think, the most important part of it regardless of how much you limit the wholeness. I mean, you do have to make trade offs but there's something about the multiple levels that's really important.

(*Bauer*) And that's a theory. What we're assuming is that you're more effective with a variety of interventions and I'm not sure that that is necessarily proven, but it's a theory I accept and it's certainly your presentation. Policy people will say that that may be redundant, that beyond a certain point you're doing more than is needed. So one is likely to encounter argument at those levels.

(*Papiernik*) The answer is *prevention is always redundant, or it's not enough.* Be careful. You have to have excess at every point of contact. This you have to accept. How many x-ray's for chest disease have we done to detect very, very few pulmonary diseases like tuberculosis. And so every type of prevention is extremely redundant. This policy is not as redundant as it could have been if not tuned on risk assessment. You can say that 60% of the women are absolutely at no risk and the specificity is good. It will predict that for this 60% there is only a risk of 2% for preterm deliveries. Whatever you do. If you give them 10 weeks of work leave, it will make no difference. They have 2% because of some abnormality of the uterus or abnormality of the child completely unrelated to what you can do with prevention. So that for the other 40 percent who are somewhat at risk and the risk is a progressive function, it's not black and white, it's white, and gray and black only at the end. So with progressive tuning, you can do the best you can. We don't use a formal risk assessment procedure any more. We did a controlled trial in putting the risk assessment sheet in one of two prenatal care systems and after three days, we found the doctors took the same decision whether a risk score was calculated or not. So this was probably medical knowledge which was already there. You can tune with the risk assessment and this is done at every prenatal visit.

(*Chamberlin*) And if the low risk person happens to be the sister of an adolescent pregnant women, who isn't coming in for care, you reach her through that channel.

(*Bauer*) Would you be willing to respond to his statement about fine tuning with the risk assessment? In many ways, isn't that slightly contrary to . . . the approach you favor in terms of not basing them so much on risk . . .

(*Chamberlin*) I would call them needs assessment. I mean people have different needs and it's a semantic sort of thing, but I would agree that you don't have to plug in the same program for everybody because people have different needs. I don't see that as incompatible as long as you realize that you have to change the whole environmental matrix as well as the behavior of individuals.

(*Little*) You lost me now and I want to pursue this point. Emile said at one point that you tell the women she is at risk and why.

(*Weil*) But he also said later on that you can't just do that. You have to do all these other things as well. Just doing that is not enough.

(*Little*) There's some fundamental concept that we don't quite have structure to yet, and I think it's one of the areas that we get hung up on. The former president of the College of Obstetrics, George Rhine, who is a professor of obstetrics interested in ambulatory and prenatal care, feels very strongly that there is no such thing as a normal pregnancy until it's gone to term and been delivered. And that's a fundamental belief in risk. You can't state it anymore clearly than that to me that no woman has had a normal pregnancy until she can look at it retrospectively. As long as we buy into that, then I think there's some fundamental problem in trying to apply what Emile has had to say here. You know, this risk thing keeps coming up again and again and I haven't heard it reconciled yet. I haven't heard Steve's question totally reconciled.

(*Berry*) I think I heard that one thing was encouraging all women to get prenatal care early and there's a lot of general public media messages for informing the consumer at large. Once they get into a system, it's doing an individual needs assessment. Every woman ought to be approached from that prospective and given the minimum of education and support, but beyond that there are people that may need a more focused kind of intervention. As science progresses, we may know a better package for 60% of women. We're developing our educational modules designed for the pregnant women who has diabetes. It's an entirely different educational model than the one you do for someone with diabetes versus someone who has twins. I don't hear a conflict, but it does sound a little confusing when you say a 'needs assessment' versus an at 'risk assessment'.

(*Chamberlin*) What you're doing by a comprehensive approach is you're preventing people from bleeding in the 3rd trimester and going into preterm labor. You don't know who is going to do it because it hasn't happened yet and you can't accurately identify those people ahead of time.

(*Papiernik*) There is some predictability. For instance, there is a relationship between hard work and bleeding which has been established. If you propose work leave for women who are nurses this is related to their risk assessment and when you modify their work load, this is effective in reducing the bleeding.

(*Chamberlin*) But it's not just the people who are working that bleed, if you look at a sample of all the bleeders, they're not all going to be nurses who are standing up all day.

(*Papiernik*) That's true. But this is one of the explanations. The women who bleed have more uterine contractions and if you aim you program at all women having uterine contractions, then you can protect some of them from having a second complication — bleeding. We are on the same wave length. If you address these questions to all women, then you have access to reduce the risk inside the population.

(*Chamberlin*) Chris, you deal with this all the time.

(*Jackson*) Well, I'm just trying to figure it out. I mean, there is a difference because we can look at the population at large and say 50% of you are likely to have cholesterol over 200 to 210 but there is a smaller segment of the population who is pregnant. So that's the difference. But beyond that we do use the concept of risk. We don't use the word 'risk' very much but we do, for example, with cholesterol screening.

(*Papiernik*) What do you say when the cholesterol is very high?

(*Jackson*) We do use the word 'risk'. But the screening part of it is really a channeling function. I mean, it really is to send people who are in need to . . .

(*Papiernik*) This is a user of your system but pregnant women know that it's good for them to come to prenatal visits and then if you measure a short cervix at 24 weeks of pregnancy or if your questionnaire says she's working 6 hours standing up a day, then she's at risk and you have to adapt something for her.

(*Jackson*) About the use of the word 'risk'. I mean, we use it in two sentences in most of what we do and that's because we're duplicating what it is that's coming down from the National Cholesterol Education Program at NIH but in general what we say is, 'the lower it is, the better and the lower it is, the healthier you're likely to be'. So there is a difference in the word but nevertheless you do have to let people know where they stand . . .

(*Papiernik*) Yes, so let us accept this point.

(*Chamberlin*) I have no argument with that.

(*Albano*) But speaking from the MCH administrator view of the world, we have to get the money and we have to justify its use. In lieu of a national policy or at least a policy in New England or a policy in New Hampshire, we do have to make choices in the sense of where we put our programs. I know there was an effort through a federal grant to try your preterm prevention project in Northern New England which, unfortunately, was not funded. I think that would have been a nice effort to actually take a look at the Northern New England states. The discussion on risk indicators I think is a parcel. We need some way to choose particular areas to justify the funds, so that at the end of the process we can actually say we had an impact on reducing something or increasing something. We can justify to our legislators that with this 100,000 dollars we were able to save x-number of years of productive life. In lieu of a national policy, what can we do to develop a program around your foundation in a specific geographic area? Do we match up education levels of less than 12 years to preterm births and say, 'this is our high risk area in such and such a location and now we're going to implement a community-wide approach with your foundation to reduce preterm births?'

(*Papiernik*) It's a real pitty you didn't get that grant. I know of this story but why don't you do at least an epidemiologic case control study for preterm births here and then in Burlington and other hospitals. It would be easy to do for the last two or three years. You should be able to get some money to do that. I would say this would be the first step to let you look at geographical areas, for possible prevention of preterm deliveries. You have birth certificates, you have death certificates, you have a lot of data that you can use.

(*Chamberlin*) I think the problem is, Charlie, if you just target all your resources to adolescents and you look at the data, only 20% of low-birth weight babies come from the adolescent population. Therefore, you're not hitting 80% of the causes of low-birth weight in your community. It's the same no matter what risk factor you use. If you just target it to that risk group, you'll help that particular group but you'll never make an impact on the community as a whole until you realize that you've got to target it toward the whole community.

(*Papiernik*) Yes, that's it.

(*Albano*) But I guess the question is Bob. Which community do you choose. I understand that and I understand the historical nature of funding on a categorical basis from prenatal care for adolescents. My question is, what community do you target? We we're talking about that yesterday. Do you send out a request for proposals, or do you choose a high risk community?

(*Papiernik*) The question is what can you do best with the money you have in your hands.

(*Albano*) Right. Do you choose an area or do you wait for the area to come to you.

(*Chamberlin*) The criteria I would use is not only low-birth weight but also child abuse and neglect and injuries. They're all connected to the same social factors.

(*Papiernik*) Ah, be careful, be careful. You should study only one idea.

(*Chamberlin*) I mean it's the same program providing education and support to stressed families.

(*Papiernik*) Yes, that's true. But if you propose a policy to reduce preterm delivery, it's clear. It's obvious that the first beating of children is to have a preterm birth. It's a severe beating of children you know and it helps to establish a better mother-child relationship if you have a successful pregnancy. It will work splendidly. So I would say, even if you have many other programs in competition, this is a splendid one that addresses completely to the whole population of pregnant mothers to be, but you have to focus it.

(*Rubino*) While we do have multiple sites around the state, we do not have sites in every community in which there's a population center. We have used a multifactor risk profile of a number of the variables that Bob talked about as one piece of the information we use to decide where grants are made.

(*Chamberlin*) Is it a risk for community or risk for . . . ?

(*Rubino*) A risk for community not for individuals and once we've established that as a part of a series of things we want to look at, then we look at trying to saturate that community. We don't try to determine individual risk profiles, which I think are fairly unreliable in the conceptually sloppy work that we're doing right now. I mean, we don't know enough to be determining that. I think there is a strong value in the broad sweep and having the advantage of better functioning families mixing with poorly functioning families and there is clearly some redundancy. There are a lot of kids who come into our programs who probably would have done just fine without our programs.

(*Chamberlin*) But you can't tell which ones very accurately.

(*Rubino*) Right. And I think that's a somewhat different issue then recognizing that the individuals who come into your programs are in fact individuals and they need different things from the program and you're not going to know what they need and when, so what you need is to have a fairly comprehensive array of things and a system in which they can make the program work for themselves.

(*Albano*) The question that I have though is from a practical standpoint. Do you put the RFP out in this particular case, asking agencies to apply for your money? I think this is the crux of the matter because the idea has to be sold. People in the community have to be educated and as we talked yesterday there are those communities and organizations who apply for everything, and there are those people in communities that we can identify in New Hampshire who, based on previous needs assessment and high risk indicators, are in great need of everything but they don't have the organizational skills or motivation to apply. So the questions is 1) how much time do you put into a community to develop that community so they can get sophisticated enough to apply, and 2) do we pick them or do we wait until they pick us.

(*Rubino*) If you're starting with a brand new concept, I would say that you need to have a match between something that you want and some readiness that they have. You don't start with your hardest place where you're going to have the least probable impact. And I think that ultimately you want to get to that point but you want to be able to develop the communities capacity to mobilize around the issues that you're concerned about. If you're starting a new policy and you're starting to build that constituency, don't start in the hardest place. I mean, the risk variables that I talked about that we developed for the whole state was only one of the variables we looked at in analyzing the responses to our request for a proposal because it needed to be matched with someone who we felt had a good idea and a credible capacity and history to make that idea actually happen in that community. It was one of the things we looked at but it wasn't the only thing. When we had two competing ideas of equal merit and agencies we felt had equal capacity, we may have tended to pick the higher risk community but it was in tandem with other things. And I think in particular, if you're starting with something new, don't start in the hardest place.

(*Mitchell*) My sense is that your data is suggesting that we should be starting with well educated, affluent women. If we've learned anything from social policy changes in day care, the push came when women who needed it said they needed it and convinced their husbands that they needed that and . . .

(*Papiernik*) In our community, when we were successful in convincing the women at least risk, then we were successful in spreading out the idea.

(*Mitchell*) In this country, most of us who were relatively well educated, were taught that there were no problems with pregnancy, so we pushed for post-partum leave. Most of us were ready to do anything that our doctors told us to do during pregnancy, at least I was, but you were never told that there was any chance that something could go wrong during pregnancy.

(*Papiernik*) In your country preterm deliveries are considered a minority problem. It's not true. This is one of the reasons that Northern New England didn't get the grant. You were not bad enough. You were not minority enough. But you had a rate of 7% for preterm deliveries and 6% for low-birth weight and if you compare these to the rates of Sweden and Norway which are 4%, then you are very bad. I agree with the statement that, if you try to reach only the very high risk mothers, you will not succeed. You have to convince the well educated people because it's a social change and such a change comes through the well-informed and well-educated women. They wanted to reduce their risk from 4% to 2% and we were successful in helping them do that in France.

(*Weil*) Going back to Charlie's point that one of the problems with RFP's coming either from a federal level or from state agencies is that they are so often unidimensional — they're targeted at adolescence or they're targeted at day care or very specific things, and the model that I was talking about yesterday in Maine is a coordination system that we've developed extensively for handicapped preschoolers which is becoming increasingly, I think, services for a wide array of young children and their families. This has created the potential within the community for a whole range of agencies coming together through this coordination system to respond to an RFP from a much more community-wide basis. So that agencies who deliver a whole variety of services are much more in a mode to coordinate those services over time than they might be in some other places. They are also more able to respond creatively to an RFP that may be targeted at one segment of the community because together they can figure out that if we respond in such and such away, that funding will help us do what the RFP is about but it also will help us do these other things as well. So you may want to help those communities that you think really need help and need the services the most to come together collaboratively to respond to your RFP's rather than just a particular agency which might or might not develop the technical expertise to write a grant. Help them collectively to pull together that expertise and think of how the funding is going to help solve more than one of their community problems.

(*Jackson*) Another way to look at your question is to start with another question which is: "What is the smallest unit of intervention within which the comprehensive approach is possible." I have a list here of the Health Promotion and Resource Center's 11 funded communities which ranges in size from the states of Colorado and Montana to urban cities and rural areas and so forth.

So how they decide the unit of intervention is an important question. I think it's what is the largest unit in which you can expect to have a sense of community, and what does that mean. It means a shared purpose, and it means an ability to coordinate program efforts to pull off this kind of comprehensive results.

(*Papiernik*) Yes, we were speaking about results and one obstetrician delivering 100-200 babies a year has no measure of the value of his work. He has no way to measure if he has 4% or 8% of preterm deliveries because one baby or two babies will die per year per obstetrician so that this describes very clearly that the one obstetrician unit is too small. It's impossible to make him understand what he's doing. But he has to have the personal result of his work. Then the unit is to be somewhat bigger than 100. At 1000 it begins to be clearly measurable.

(*Albano*) The 1000 number was one that we used for the development of the WIC program that I was involved with in 1974. We just couldn't start a program with five people so we had a cut off of 1000 people per site. This way you could mobilize your person power in the sense of an appropriate number of nutritionists and people who could intervene in the social welfare of the client and make deliveries in the practical sense. You had to have a cut off, and that's what I wanted to touch on again and we could do that tomorrow. But you have to have some numbers. However you determine them, there has to be a number that you work with so that you can have those agencies with those multipurpose points.

(*Chamberlin*) We'll certainly touch on that in Scandinavia because they've determined what makes a reasonable catchment area for a variety of programs.

(*Papiernik*) In Scandinavia they have recently decided there is no way to have a birth place for less than 1000 births per year. This is one of the major decisions they have made.

(*Bauer*) The comment that was made that maybe we should direct our resources to the more educated mothers and their families because they're most amenable to change indicates how complex this whole question is because another way of looking at long-term outcomes, is to look at the outcome of the children who are born prematurely. There is a body of pediatric literature that suggests that if you wanted to predict who is going to do best in the long run at the time of birth among the low birth weight babies your best indicators would be the education and social status of the family. That could perhaps then be made into an argument that if you're going to be born prematurely, it's best to be born into a family that has means. And to prevent prematurity, you'd be best advised to put that effort in, even if it's harder, to modify the behavior of somebody less educated, who is the person who needs the effort more in terms of the outcome years down the line.

(*Papiernik*) I would not accept that.

(*Bauer*) I think, there's enough truth to that to raise the complexity of the issue.

(*Papiernik*) We have followed the newborns in Haguenau and looked at them at 6 years, at the time of entry into the school system. Even if you are rich and very well educated, to be born preterm makes a difference. Your baby can be retarded if it's born preterm. This is the result of our observation. You cannot modify the social gradient of the mother or the father. You can tell her to participate in a program that all women will be involved in even if the rich and more educated will profit more immediately. The basic idea is to spread out the proposal for all women in the community. Obviously, the more educated will use it immediately and the others will wait until they are convinced. To convince the well-educated you have to tell them that their baby at term is much better at 6 years, in the school system, compared to a baby born preterm, even for them.

(*Weil*) I had one other question about getting your government to look at the reduced cost related to reducing preterm babies compared to the increased cost for the work leave. Since these costs are paid out of two different parts of your system, cost saving in one wouldn't matter much to the decisions of the other.

(*Papiernik*) Yes. This data is only to convince you because nobody in our government looked at it. Politicians are not interested by reality. We have sold them the system on that political cost-effectiveness calculation 15 years ago and it's written that we will save money by preventing preterm babies but we had no data at that time that they could look at and yet they gave us money. Further more, when the results did come out, they didn't look at it.

(*Weiss*) I think this discussion reflects an interesting difference in cultures and, as I understand French policy, given your birth rate decline in the 19th Century, you really pursued in the 20th Century an aggressive pronatal policy.

(*Papiernik*) We tried to. Yes.

(*Weiss*) But I think this speaks a different view of the value of children than we have in this country.

(*Papiernik*) I would not say that. You are paying how many dollars to care for babies in intensive care?

(*Weiss*) I don't dispute that. But the point you just made is interesting in the sense that in this country cost effectiveness speaks loud and clear whereas your saying you sold them on this policy 15 years ago and nobody has ever checked the books to see if it is working. In our government they would.

(*Papiernik*) Ah, 15 years after, you have yet to establish the effectiveness of the WIC program.

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Community Wide Approaches to Promoting the Health and Development of Families with Children: Examples from Scandinavia and Great Britain*

Presentation by Robert W. Chamberlin

INTRODUCTION

In looking for workable examples of community wide approaches to strengthening families, one is immediately led to the Scandinavian Countries. Programs in these countries have all or most of the basic characteristics we see as needed for an effective and efficient service system. These include a defined geographic catchment area with an adequate population base, a co-ordinating council made up of local residents, a comprehensive array of high quality non deficit oriented programs open to all, and stable long-term funding based on national legislation and cost sharing between national and local governments and consumers.

These countries have many similarities to the United States in terms of a long tradition of democratic government, a mixed economy that is predominantly (85 to 90%) private enterprise, a high standard of living, a high quality health care system, and high value on local control of programs. They are faced with many of the same economic and demographic changes: a falling birth rate and an increasing number of senior citizens, high divorce rates and births out of wedlock, an increasing number of single parents, an increasing percentage of mothers with young children entering the work force (70-80%), many young families moving to the cities and living away from grandparents and other relatives who used to be available to help out with emergencies in the past, and a changing work scene with the economy shifting from manufacturing to a service industry base.

Major differences are smaller size (population 5 to 8 million), a more homogeneous population (although this is changing somewhat as large numbers of foreign immigrants are settling in the larger cities), and markedly different attitudes about the importance of health and social welfare programs to promote the health and development of families. This latter fact is born out by the willingness of local residents to vote in year after year the tax rates necessary to fund these programs (40 to 50% of gross income for middle class families).

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*This is an expanded version of the conference presentation.

Births, Infant Mortality Rate, Teenage Prenancy Rates and % Low Birth Weight for Selected Countries

Country	Births (x 1000) 1984	I.M.R. 1984	% Births to Women <20 1984	% L.B.W. 1979
Japan	1489.7	6.0	1.2	5.1
Sweden	93.7	6.4	3.8	4.4
Finland	65.1	6.6	4.3	4.1
Denmark	51.8	7.7	4.2	5.5
Great Britain	729.6	9.6	8.6	7.0
United States	3669.1	10.7	13.7	7.4
New Hampshire	12.6	10.2	10.0	5.9

When compared to the United States, all these countries have significantly lower rates for births of low-weight babies, perinatal and infant mortality, induced abortion, adolescent pregnancy, and child abuse. There is also some evidence suggesting lower rates for the types of mild mental retardation that are thought to have a significant environmental component. That these low rates are not artifacts related to the differences in size and ethnic diversity is brought out when one sees that they are also lower than the rates of small ethically homogeneous states such as Maine, New Hampshire, and Vermont. What do families in these countries get for their money and how are all these programs coordinated and integrated?

BASIC BENEFITS PROVIDED

Income and Job Protection with Flexible Work Schedules

These include: universal sickness, disability, and unemployment insurance; basic and supplemental retirement pensions; free tuition for academic and vocational training, and job retraining and assistance with relocation for those displaced from jobs by a changing economy. These benefits are available to both part time and full time workers and are not lost when a person changes or loses his or her job or works part time as happens in the United States.

Mothers have up to a year of paid maternity leave and this can be split between mother and father in Sweden. In Finland and Denmark, there are several days of paid leave available for care of a sick child in the home and in Sweden, up to 60 days of paid leave per year can be taken in this way. Mothers of young children have the option of taking longer unpaid leave or working six hours a day until the youngest child is age six. There is also paid educational leave for those wishing to upgrade their skills.

Financial Assistance and Housing

Cash Allowances: A yearly cash allowance is provided for each child up to age 16 with additional amounts added for a premature baby (up to age two) a child with a handicap, a single parent, five or more children. A cash allowance is also given to non-working mothers for six months during her pregnancy.

Child Support: For divorced mothers, child support is provided by the local community who then assumes the responsibility for collecting this from the father.

Housing: Subsidized housing is provided for low income families and temporary living quarters are provided for up to a year and sometimes two for mothers with young children coming from an unstable living situation. This is one of the only programs that is means tested.

Accessible Preventive and Sick Care Health Services

Preventive/Promotive Health Services: In all these countries, there is a nationwide network of maternal child health services provided in neighborhood maternal and/or child health centers and/or through home visiting nurses. These include parent education and counselling as well as immunization, monitoring of growth and development, preventive dental care, prenatal and postnatal care and family planning. These may or may not be in the same location as primary health care clinics staffed by general practitioners in Finland and Denmark and a mixture of general practitioners and pediatric and obstetrical specialists in Sweden.

Sick Care: Subsidized primary care includes outpatient visits, x-rays and laboratory tests, prescribed pharmaceuticals, and transportation to and from rural areas without a good public transportation system. These services are generally provided without cost. A nominal fee of $7 or $8 per day is paid by the patient for in-patient hospital care. On the average there is about one primary care clinic per 10,000 population staffed with 3 to 5 general practitioners and one regional hospital, per 300,000 population staffed with specialists providing back up consultation and treatment. A private practice option is kept open in these countries by paying specialists on the basis of a 36 hour week and allowing them to earn extra money through private consultation during off hours. About 20% of outpatient visits are to private practitioners in Finland and Sweden. National health insurance covers about 35 to 40% of the costs for private consultation and the patient pays the rest.

In Denmark, where an independent physician organization contracts with the state, two options are available for patients. If the consumer elects to go through the general practitioner for all care these is no charge for referrals to specialists, but the patient can only change primary care physicians once a year. The second option allows unlimited choice of general practitioners or specialists but the consumer must pay part of the costs.

Most primary care centers have rehabilitation services for those with handicapping conditions or chronic illnesses. These services are backed up by specialists available in each county. Expensive specialized equipment is also provided at the county level.

Programs for Children and Youth

Day Care and Preschool Programs: There is a neighborhood network of high quality subsidized day care and preschool programs available on a priority basis for working mothers, full time students, single parents, and for children in need of special services because of handicaps, developmental delays and/or unstable or stressful living conditions. Center programs are neighborhood based and directed by teachers with three years of training in early childhood education. Roughly about one third of the cost is provided by the federal government, one third by the local government, and one third by the parents.

Day care and preschool programs are neighborhood based and under the supervision of social welfare rather than education because it is felt that social services are more oriented toward families and parent education than the school system. There are few, if any, day care programs in business settings because if is felt that children should get to know the neighborhood children they will eventually be going to school with and not be subjected to changes in setting when the mother changes jobs.

Family day care mothers receive short term training, are provided educational materials, and limited to having no more than four children at any one time including their own. Their programs are monitored for health, safety, and educational content by early childhood educators and health care providers employed or contracted for by the local municipality.

Youth Programs: After school programs for children 7-10 are usually available in center based day care settings while youth clubs run by the municipality recreation department are available for older children. These include instruction in bike and car repair, sports, music and dance, crafts, etc.

Parent Drop In Centers: In Sweden, there is also an extensive network of open day care centers where non-working mothers in the area can drop by for coffee, or to participate in scheduled activities while somebody minds their children nearby. Sometimes this is a flat in a high rise apartment or takes place in a section of a community center which is available in most areas of this country. This has been especially helpful in breaking down the isolation of newly arrived immigrants from places such as Turkey, Bangladesh, or even neighboring Finland. An interpreter is available for different countries on a regular schedule. These places are referred to as open day care centers. These are not available in Finland and Denmark except where a private organization such as Mothers Aide in Denmark has established some centers in big cities.

Other Family Support Services: Local or county social service departments provide family and child counselling services and trained home helps to help with household and child care in times of family crisis such as having a mother die or be hospitalized with an illness or emotional problem. Low income mothers with stressful living circumstances are provided one or two weeks of paid vacation with or without children at a local resort.

Programs for the Elderly: In addition to these programs for families, children, and youths, there is a similar extensive network of services for the elderly including drop in centers, meals on wheels, assistance with home care, housing allowance, and or service flats, subsidized cultural events, hobby and recreational programs, and transportation.

EVOLUTION OF PROGRAM DEVELOPMENT THROUGH LEGISLATION

Funding: All these programs are funded through a combination of taxes, social insurance, and user fees. The legislative time table for putting maternal and child programs into operation for all these countries is roughly as follows:

YEARS ESTABLISHED	PROGRAM TYPE
1930's-40's	Neighborhood Maternal Child Health Services.
1950's-60's	Job and Income Protection Health Insurance Paid Maternity and Paternity Leave
1970's	Dental Programs Abortion on Demand Child Care
1980's	Parent Education Joint Custody

The legislation insures that all communities provide certain minimum basic services but the actual level at which they are provided and how they are organized, coordinated, and monitored is up to the local and/or regional popularly elected councils.

RATIONALE FOR PROGRAMS

When asked how they can justify spending this much money on human services, providers and consumers are likely to respond with one or more of the following:

Families should not be penalized economically for having children; high quality services should be accessible to all community residents regardless of the type of problem, geographic location, or income level. A major emphasis should be on prevention.

Other frequently expressed values are: Women should have freedom of choice as to the number and spacing of children and that children have the right to be wanted when they are born. Consumers should have some choice over health care providers and there should be local control over how services are delivered; educational day care programs are beneficial to the child and equal access to educational opportunity must be maintained; subsidized day care is necessary for children who need special care and encouragement in their development.

Some quotes from official publications are as follows:

"The health and welfare of the citizens are a prerequisite for a harmonious and well functioning society." *Danish Minister of Interior.*

"It shall be the duty of the local social welfare committee to supervise the conditions under which children within its area live and to support their parents in the upbringing and care of them." *From Denmark's Social Assistance Act of 1974.*

"The task of the social service is to help create a favorable environment in order that the need of individuality oriented means tested programs will be reduced." *Sweden.*

ORGANIZATION OF SERVICES

Each country is organized at three levels of administration: national, regional, and local. At the national level, health and social service policy is developed under one or more ministers appointed by the president (Finland) or prime minister (Sweden). Each minister receives information and advice from a board of lay persons and professionals with special knowledge and/or interest. For example, in Finland and Denmark there are separate ministers of health and social welfare and each has its own advisory board of professionals. Sweden has one minister of Health and Social Affairs and one advisory board of health and welfare. The ministers and board are responsible for providing information to Parliament, drafting legislation, developing five year plans, and setting general policy guidelines. They also propose an overall budget and work out regional reimbursement methods to insure equal access to services regardless of where one lives.

Regional administration takes the form of counties (Denmark and Sweden) or provinces (Finland). In addition, some countries are divided into regional hospital districts which are different from the political divisions. Each region or hospital district has an average population base of two to three hundred thousand people. Large cities such as Stockholm and Copenhagen are also organized as a region rather than as a local municipality. The head of regional government is appointed by the president (Finland) or selected from elected officials making up the county council.

Local government is in the form of municipalities or Kummuns as they are called in Scandinavia. These can consist of a medium sized city of 100,000 people, an area of twenty thousand people with several small towns, or a sparsely settled rural area of 6,000 people.

Following the general guidelines issued at the Federal level, local governments make up five year plans outlining projected needs for personnel and facilities. Regional administration puts these together and forwards them to the national level. The Minister of Health and his or her board look at all the regional plans and allocates resources according to nationally established priorities. These funds are sent to the regional government which in turn allocates them to local governments in their region on the basis of regional priorities. Both county and local governments have the authority to raise revenues through taxation and programs are financed through a mix of federal, state, and local taxes and user fees.

In Denmark, county government is responsible for the specialist staffed general hospital inpatient and outpatient care system and the midwife run maternity centers which provide most of the prenatal and post partum care. These maternity centers may be free standing or attached to a regional hospital where almost all deliveries take place. In addition, county government, through their health and social service committees of elected representatives and their administrative staff, oversee the management of specialized institutions for severely physically and/or emotionally handicapped persons. The county is also responsible for the mental health care clinics. Finally, they are in charge of monitoring the primary health care system established through negotiations with an independent body of general practitioners. Local government is responsible for the home visiting child health and district nurses, the dental care and school health programs, and all the day to day social services including child care programs and home helps.

In Finland, the counties are also responsible for special care services such as mental health clinics, programs for the handicapped, and inpatient psychiatric and T.B. hospitals. Local governments, however, are responsible for all day to day services including primary health care, child care and youth programs, home helps and other social services, maternal and child health preventive programs, dental care, school health, care of the elderly, home nursing, and rehabilitation. However, since it has been determined that a minimum population base of about 10,000 persons and at least three general practitioners are needed to provide an efficient primary health care system and since the average population per community is about six thousand, it is necessary in some areas, for two or more communities to join together to form an adequate sized health district. There are about 461 local communities in Finland and 213 health care districts. About half of these are federations of two or more municipalities. In a like manner, communities form larger federations to form a population base of about three hundred thousand to support a specialist staffed regional hospital. Each municipality pays for a set number of hospital beds according to their population.

In Sweden, the county councils oversee the entire health care system including primary health care, maternal and child preventive programs run by nurses, and specialist staffed hospitals. Local communities are responsible for social services which include child care and home helps.

In all countries at each level, programs are monitored by a health and social service committee made up of elected officials. The services in turn are administered by civil servants working for the local or regional government.

CONTENT OF PREVENTIVE HEALTH SERVICES

Prenatal Care: In an uncomplicated pregnancy, the average expectant mother makes 15 visits with about twelve to the midwife or public health nurse and three to the physician. Besides monitoring the health status of the mother and fetus, information and counselling are provided on nutrition, smoking, use of alcohol, avoiding exposure to other toxic substances, and on other factors that can influence pregnancy outcome. Group sessions are held covering such topics as physiologic and emotional changes during pregnancy, preparation for labor and delivery, preparation for breast feeding, and information on child spacing. If a complication is suspected or the mother falls into a risk category because of previous difficulties or a highly stressful life situation, she is referred to the regional hospital and followed up by the hospital midwife and obstetrician. Each community based midwife follows about 50-100 women at any one point in time. Standardized records are used across the country in all clinics and hospitals.

Child Health Care: During the first year of life the child is seen about ten times for well child visits—seven by the nurse and three by the physician. In Denmark, the child health nurse works out of an office in the social service department and makes all her visits in the home. In Finland, the child nurse works out of a maternal child health center which may be free standing or attached to a primary health care clinic. One or two home visits are made shortly after the child is born, but the rest of the visits are held at the center unless the mother doesn't come in or has some special problem. In Sweden, the child health nurse works out of a maternal child center and does a home visit shortly after the child is born and again at about eight months of age to check for hearing and to educate the mother about what she can do to prevent injuries in the home. In Finland and Sweden, group sessions are held at the centers to go over basic child care techniques, stages of child development, and management of common problems. Fathers can come to these also and some do. A more detailed developmental assessment is conducted at specified age periods such as 4 in Sweden, 18 months and 4 in Denmark and 2 and 5 in Finland. Common forms for recording prenatal and well child care are available throughout each country. The child health nurses do not do complete physical exams using a stethescope and otoscope.

Each nurse is responsible for following about 4- or 500 children under seven with no more than about 60 to 80 under one and 140 under age two. This means that it is unusual to see a family more frequently than once a month. In Denmark, with all home visits the average is about 7 visits during the first year. A typical day for the Danish home visitor is five one-hour home visits, two complicated and three routine. Only about 20% of families are thought to need regular home visits after the child is one year of age. About 50% of families receive regular visits up until one and in 30%, visits have stopped before the child's first birthday. In Finland, where most mothers and children are seen at the neighborhood center, the nurse may only do about five home visits a week and the average per child is two the first year of life. In Sweden, the nurse usually makes one to two home visits a day with an average of three per child over the first year of life.

Clinics are open during day time hours on weekdays. Some have evening sessions for working mothers and some have call-in times at noon. Clinics are generally not open on weekends.

Quality Control: The bulk of the preventive child health and prenatal care services are carried out by specially trained public health nurses. The general training for these persons is a 2½ year general nursing program, a one to two year work experience followed by a year of focused training in maternal child health. Hospital based midwives who do most of the normal deliveries have had one or two additional years of training. The bulk of primary care is performed by general practitioners who have had about five and a half years of postgraduate training after medical school. In Denmark and Finland, general practitioners work with these nurses seeing an expectant mother two or three times during a normal pregnancy and the child two or threetimes during the first year. Pediatricians and obstetricians remain based in the hospital and only see patients as consultants. In Sweden, although generally hospital based, some pediatricians and obstetricians work in the community with the maternity and child health nurses taking the place of or alternating with the general practitioner for preventive work and sometimes for sick child care as well. These community based specialists often are responsible for the quality of care in a health district.

Staff at day care centers generally consists of a director with two or three years of graduate level training in early childhood education and several assistants with one year of post secondary school training. Some helpers also have one or two years of vocational school training.

School Health Programs: After the child enters the public school system at age 7, health education and monitoring is taken over by the school nurse, who does annual measures for growth, vision, and hearing. Health Exams by a school physician are conducted at ages 7, 11, 14, and 17. One nurse is responsible for 7- or 800 students and one physician per 1000. In Finland, the nurse monitors the school environment as well as the child, looking at sanitary conditions, safety, and the climate for emotional health.

An extensive program in sex education is carried out through the primary school grades in all three countries. In the first four years (ages 7 to 11) this is part of a general series on how various systems of the body work and is carried out by a regular teacher. At ages 12-13 changes associated with puberty and boy/girl relationships are discussed by the school nurse. Contraception is discussed with 14 and 15 year olds also by the nurse. Some information is conveyed about how smoking, alcohol, and nutrition affect the growth of the fetus, but not much is given on stages of child development and what parents can do to promote a child's development after it is born.

A school psychologist and social worker are available for back up with complicated problems. In Denmark, each county has a neurologist and child psychiatrist available for consultation on learning problems and a comprehensive multi discipline evaluation center is located in Kopenhaven.

Programs for Handicapped Children: In Denmark, the names of children born with a handicap are sent to the local municipal authority who sends a visitor to the home to assess needs and to facilitate resource access. A register of handicapped children is kept to insure that none get lost from sight.

Children identified as having developmental delays in primary care settings are referred for more extensive evaluation by a school or social service employed psychologist or to a pediatric specialist or multi discipline team based at a university hospital. Low birth weight babies are followed by pediatricians. In Finland, speech therapists and psychologists are available on a regular schedule at the maternal child health clinics. Most children with mild to moderate handicaps are followed in regular day care and preschool programs with special facilities reserved for those with severe disabilities.

In Denmark, hospital beds are available for severely handicapped children to provide respite for parents who want to take a short vacation or have a free weekend. In Sweden, residential areas promoting independent living for moderately handicapped persons are integrated into regular housing developments. Expensive electronic equipment is available from county centers and supplied at no charge to facilitate mobility and self care.

Dental Care: In Denmark, dental care is free up to age 16. Programs in preventive dentistry are introduced in day care, institutions, and schools. In Sweden, dentists come into the child health clinics for an exam and education when the child is 6 and 18 months of age and 3 or 4 years old. In Finland, dentists are based in the maternal child health centers and participate in the exams on a regular schedule.

COORDINATION OF PROGRAMS

The wealth of services provided by these countries also present problems in coordination. Primary health care, prenatal, and child health care are carried out by different persons, sometimes in different locations. Prenatal care is carried out by a nurse in the community but the mother is delivered by a different nurse midwife or specialist in the regional hospital. Catchment areas for social services, maternity and child care differ and providers often work under different administrative structures. How are all these programs coordinated?

While no one method is entirely satisfactory, efforts to improve coordination generally included some combination of the following options:

1. *Mother Held Health Card:* In all three countries each mother is given a nationally standardized health card for herself and each child. Significant information is recorded on this at each encounter with the health care system. For the child this includes birth information, hospitalizations, chronic and/or recurring illnesses, medications, growth measurements, immunization, dates of developmental milestone achievement, and the results of developmental screening. For the mother, there is a card for each pregnancy which includes prenatal information and a summary of labor, delivery, and pregnancy outcome.

There was little problem with lost or forgotten cards, as long as the health care provider emphasized the importance of filling them out. In Finland and Sweden, either the entire preschool record or a shortened summarized version accompanied the child in the school system.

2. *Providers Working Out Of The Same Building:* Communication both formal and informal was much improved if service providers worked out of the same building. In Denmark, visiting child health nurses worked out of the same office as social service and communication was generally good with much of it being informal in nature. Having a maternal child center attached to the primary health care center, in Finland improved communication between physicians and nurses. Health centers, who either employed their own social worker or who had one physically assigned to them by the local office, had better communication than ones working in different locations even if quite close geographically. Attached maternity and child health centers such as in Finland improved communications between midwife and child health nurses.

3. *On Site Visit By One Provider to the Care Site of the Other:* In Finland, a regular schedule of primary care physician visits to the maternal and child health clinics for special examinations facilitated communication between nurses and physicians. Visits by child health nurses and/or physicians to family or center based day care centers facilitated communication between teachers and health providers. In rural areas of Finland, the child health nurse also served as a school nurse so that continuity was maintained from infancy through age 18.

4. *Geographic Continuity:* In most places, each provider had a specific geographic catchment area that he or she covered. Although boundaries were often not the same, there was usually enough overlap so that providers got to know each other well; in large cities, however, where large numbers of persons were located in small areas, a home visiting child health nurse may have to relate to a dozen or more physicians (Denmark). In places where catchment areas coincided with natural neighborhoods, communication and coordination was facilitated. (See Haga example).

5. *Cohort Continuity:* One of the problems with assigned geography catchment areas is loss of continuity when a family moves. In some places, this could be just across the street. In one medium sized town (30,000) in Denmark (Holbaek) it was found that better continuity was maintained by having cohort rather than geographic continuity. Each nurse followed all the families of one or two primary care practices wherever they moved as long as they stayed within the municipal boundary. Since geographic distances were not large and transportation easy, this worked well and provided for a close working relationship between the home visitor and the primary care physician. This method would not work in large cities where transportation across town is a much more time consuming and difficult procedure.

6. *Periodic Formal Meetings Between Providers:* In some areas, monthly or quarterly meetings were arranged between social services, nursing, medical, and day care providers to discuss common problems and families. Physicians frequently did not come to this even when paid a small amount for the time involved. Again, this works better in smaller towns where there are fewer providers and easier access in terms of transportation, parking, etc. A few places held periodic weekend retreats to address problems of coordination. In Denmark, some communities had periodic meetings between social workers, health visitors, and school nurses and between police, social workers, and school officials to coordinate approaches to troubled children and their families. Hospital midwives meet periodically with community based midwives to review care and exchange information.

7. *Exchange of Information Through Standardized Records:* Notice of positive pregnancy tests are sent to the area midwife as well as the primary care physician. Birth notices are sent to the towns, the child health nurses, and the primary care physicians. If the mother is single, a copy is sent to social service as well. Discharge summaries for pregnancies are sent to the area midwife and primary care physician. Records are standardized so that the same forms are used nationwide.

8. *Joint Education and Assessment Activities:* In Finland, maternity and child health nurses work together providing parent education to groups of expectant mothers. Nurses provide some health related education to youth clubs in all three countries. Child care teachers work with nurses in some areas to plan for mainstreaming handicapped youngsters and to work out health policy procedures such as handwashing, management of sick children, and injury prevention and treatment. Although generally not done now, it was suggested that the day care teacher participate in the periodic developmental evaluations because they can provide information on the child's language and social development.

9. *Overall Coordination by a Health and Welfare Committee of Elected Officials and it's Professional Advisory Board:* This group is ultimately responsible for oversite of all the local programs and receive complaints and/or suggestions from consumers. They formulate a five-year plan which is updated yearly. In Finland, the head primary care physician met weekly with the municipal council.

Barriers to Coordinated Care: Besides multiple providers, other barriers to continuity and coordination of care were the geographic mobility of clients, and periodic absenses of up to a year for pregnancy leave by midwives and child health nurses. Also many areas reported a fairly high turnover of social workers thought to be related to "burn out" from having to spend so much time working with difficult families.

In some areas, there is a movement to have the same nurse visit both families with young children and the elderly. This has raised concern about her being spread too thin and having difficulty in keeping up to date on the latest developments. The declining birth rates and increasing number of senior citizens will increase the possibility that home visiting nurses will become more and more preoccupied with the elderly. This has happened in some areas of the United States where the same nurse assumes multiple roles which has generally lead to a decline in home visits to families with young children.

Finally, some Scandinavian governments are cutting back on funds for primary prevention which is translated into fewer nurses having to see larger numbers of families with less frequent visits and less time for meeting with other providers to improve coordination.

EXAMPLES

Haga: An Example from Sweden: Haga is a geographically and politically defined section of Orebro, an industrial city of 100,000 population in central Sweden. Haga has a high density population of 14,000 with apartments containing as many as 2,500 people on a single street. Fifty percent of the mothers are single and there are many social problems.

All health services including prenatal, child health, primary care, specialist consultation, district nurses, plus social service and home helps are based in the clinic which is located next to the main community center. This center contains a library, a swimming pool, and retail stores. The town also has open space areas with playgrounds and traffic free sections. The clinic is staffed by four or five general practitioners, six or seven social workers, eight full time district nurses, two part time district nurses and two midwives. The services are coordinated by dividing the area into six geographic sectors. Each sector has an assigned general practitioner, two district nurses, and a social worker. They meet as a team one to two times a week plus there are many informal meetings over coffee, lunch, and office drop in.

Two midwives cover the whole area. A pediatric consultant comes to the clinic for four hours once a week and an obstetrical consultant comes in once a month. The general practitioners also provide medical consultation to the schools and day care centers located in the area.

Much planning went into how to coordinate services and work out space arrangements before the building was constructed. It was also found that considerable time and patience was necessary to try and understand each other's perspective which was coming from quite different training and experience. Social workers were oriented more toward treatment of severe family pathology and the nurses and physicians oriented more toward primary prevention.

The Towns of Vantaa, and Nikkila and the Province of Keski Soumi In Finland: In the health district Vantaa, that I visited near Helsinki, there was a population base of 144,000 people with about 2,400 births per year. There were 7 health centers in that area (one per 20,000 population) and 17 maternal child health centers (one per 8,500 population, one per 141 births, or one per 930 children under 7). The average work load for the nurse midwife was approximately 100 women to be followed for prenatal care. After birth a child health nurse follows between 400 to 500 children under 7. About 70 or 80 of these will be under one. For this community an average center would have two midwives and two child health nurses. Each health center and maternal child center have a defined geographic area that they cover. For social service, there were 7 geographic catchment areas, about 1 per 20,000 population which may or may not coincide with the health district area.

Being a suburb of Helsinki, there was a fair amount of moving in and out of this health district with an estimated 10,000 people moving in during the year, 10,000 moving out and 10,000 moving within the area. This is also an area of young families with a birth rate of about 17 per 1,000 population. The center that I visited actually had 4 child health nurses and 3 maternity nurses. This was a 2 story building with family planning on the 2nd floor. Also a speech therapist, occupational therapist, psychologist and nutritionist were based in this building. These centers are financed by the local community of Vantaa with 43% of the cost reimbursed by the national government.

Another example of how services are organized is the province of Keski-Soumi, that I visited in central Finland. This had a population of approximately 248,000 people with about 3,000 births per year, giving a birth rate of 12 per 1,000 population. This Province is made up of 32 communities which were divided into 11 health districts. The average population per health district was 23,500 with a variation of a low 6,110 in a rural area to a high of 65,453 in the largest city, Jyvaskyla. In each district, there was at least one maternal and child health center in each town with the biggest town, Jyvaskyla having 10. For the total population of 248,000 there were 55 maternal and child health centers or about one per 4,500 inhabitants. This varied from one per 1,500 in several small towns to one per 6,453 in the largest town. There was also a social service office in each community and at least one child care center in 22 out of the 32 communities. The regional hospital was in the largest town and the farthest community from the hospital was approximately 90 miles away. Besides looking at services in Jyvaskyla, the largest city, I visited the Sarijarvi health district in a rural area. This district was made up of six communities with a total population of about 23,722 and about 300 births per year. There were two main health centers in this area plus 4 satellite clinics and 6 maternal and child health centers, one in each community. The communities ranged in size from 1,376 [illegible],585. In addition, there were 3 day care centers handling [illegible] 60 children between the ages of 3 to 6.

PROVINCE OF KESKI-SUOMI IN CENTRAL FINLAND

TOTAL POPULATION 247,799 3000 BIRTHS BIRTH RATIO 12/1000
32 COMMUNITIES 11 HEALTH DISTRICTS 1 CENTRAL HOSPITAL

HEALTH DISTRICT	POP.	# TOWNS	MCH CTRS	DAY CARE CTRS.
1. HANKASALMI	6,110	1	2	1
2. JOUTSAN SEUTU	7,308	3	5	0
*3. JYVASKYLA	65,453	1	10	36
*4. SAARIJARVEN-K.S.	23,722	6	6	7
5. KEURUU-MULTIA	15,556	2	4	2
6. LAUKAA	14,727	1	3	7
MEAN =	23,500	32	1/4,500	1/300

A third example was a small district outside of Helsinki containing about 14,000 people with 152 births per year, Nikkila. For this district there were 7 physicians with one main clinic and 2 satellite clinics. The child health nurses visited both families with young children and the elderly population. There were 580 child care places for the children with 186 of these being in family day care homes, 211 were in town run centers and 183 were in privately run centers.

The Buddle Lane Family Center in Exeter England: Although the quality of programs in Great Britain was much more variable, one of the best examples of a coordinated community wide approach to primary prevention through interagency collaboration that I encountered was the Buddle Lane Family Center in Exeter, England. When taken over by the current director, Felicity Thomas, in 1982, the Buddle Lane Day Nursery housed 60 children in two rooms. It was located in the midst of a working class neighborhood with row houses but had no defined catchment area. There was little or no staff interaction with the parents and community, and no contact with the health care system except by referral. There was lots of vandalism from the neighborhood. The center was run in shifts, 6-2 p.m., 2-5 p.m., and 7 a.m. to 7 p.m. with little pupil staff continuity.

The director made a proposal to the local education authority to develop a community based program through collaboration and support by social services, the local health authority, and the Department of Education. Social service agreed to pay for maintenance of the facilities, transportation costs, and family counselling. Education agreed to furnish educational materials and books and pay the salaries of two teachers. Health provided no money but had a physician visit two afternoons a month to examine children and answer parent questions and facilitate interaction with home visiting public health nurses working in the area. Hours of operation were reduced from 8:30 a.m. to 5 p.m. For full time working mothers, the school linked up with a nearby family day care mother. The children were divided into three groups. Two of the groups involved 3-5 year olds and enrollment was limited to children living in the surrounding area. The third unit worked with dysfunctional families with a child under three who were referred in from all over the city by social service. To develop continuity and community ties, teachers made home visits on all the children in their group to become better acquainted with the parents and the neighborhood. The school also sponsored the development of several mother-toddler groups around town. A room in the center was turned over to the parents to use for meetings and activities as they saw fit. A toy library was established in it so the parents could borrow and make use of educational toys. This room became a neighborhood meeting place for an exercise program and video club. A staff parent session was scheduled one afternoon a week. Links were established with two area health centers with one of the physicians coming over two days a month to hold a clinic. Links to the local library were developed so that parents could borrow books easily or buy at a reduced rate. Relationships were established with five schools in the area in terms of sharing resources and having children of coming school age visit to become acquainted with the surroundings and the teacher. The playground was made available to family day care providers in the area.

Participation of health visitors was sought in helping to decide which children should be placed higher on the priority list for admission and to provide input for periodic reviews of children and families. The center was also used as an initial placement of handicapped children to see how they would fit into a school environment.

For the dysfunctional families with children under three, joint meetings with social service are held frequently and a social service person is usually present for the family reviews held on every child. The school, however, has elected not to have a full time attached social worker. On site consultation was also available from speech therapists, and psychologists, for children with specific problems.

Finally, various community wide fundraising activities gave further visibility and opportunities for community participation. The center is advised by a panel of advisors with representatives from education, social service, health, playgroups, and two parents.

THE ROLE OF PRIVATE FOUNDATIONS

Given the large commitment to these programs by the governments of these countries, I was surprised to find that there was still an important role played by the private sector as well. In each country private foundations performed a variety of functions including serving as advocates for the legislation necessary to fund these programs, piloting new programs, and filling in gaps of services. Following are examples of these activities from Finland, Denmark, and Sweden.

The Mannerheim League for Child Welfare: A Citizens Organization for the Benefit of Families in Finland.

"The Mannerheim League for Child Welfare is an organization that works for families with children. It works on behalf of the child together with families and authorities. The League's members are mothers, fathers, grandparents, young people, professionals in the affairs of families, and children, and others concerned about what is best for the child. Through the Mannerheim League for Child Welfare, people and families help support each other. The League seeks to create the material and psychological basis necessary for family security and to ensure the healthy development of the child. Every child is important. The Mannerheim League for Child Welfare uses its influence to bring about improvements in the circumstances in which children live. The League works for reform and experiments with new ideas to improve all aspects of the child's life."

Founded in 1920 the League has an impressive record of accomplishments. The earliest example of the League's success was the initiation of a nationwide network of maternal child health centers for prenatal and child care up to age seven in the 1920s. In the 1930's they developed a program to train "Home Helps" to help families with household management and child care in times of crisis. In the 1940's they helped establish local health centers and preventive mental health programs for children. In the 1950's it was mass screening programs to detect hearing loss and improving the care of low-birth weight infants. In the 1960's it was stimulating discussions about day care, launching supervised day care in private homes, introducing youth polyclinic services, and establishing an information center for poisoning and accidents involving children.

Recently the League has completed a curriculum and training program in the arts for teachers, parents and pre-school children, particularly those in day care settings. This includes making and playing musical instruments, music and movement activities, making and using puppets for theater experience, "Nursery Rhyme to Story Time," which includes a guide to children's literature and how to bring it to life to stimulate a child's interest, and a section on drawing and pictorial arts. Day care teachers are trained in its use and they in turn train parents to continue the activities in the home.

The League has also developed an extensive program of parent education that is being carried out in group sessions held in the prenantal and child health centers. Similar sessions are offered through adult education centers that operate in all Finish municipalities and an expansion into the public school system is also being planned.

In terms of community wide development the League has been active in reviving traditional Finish games that are fun, further development, and in which both parents and children can take part. Once a year, on the UN Rights of the Child Day, the League organizes a Fun Sunday. In 1983, 60,000 people in over 400 communities enjoyed an afternoon of play. The League provides information, materials, instruction in traditional forms of play, and the training of play leaders.

In addition to organizing community events, the League does a good deal of "Social Marketing" by publishing a quarterly magazine for subscribers, holding press conferences for published books, supplying periodic articles to the mass media, providing handouts for maternal child health clinics and day care centers, and posters for stores and office buildings.

The practical work of the League is carried out by some 42,000 Finnish citizens in their local associations of which there are more than 400. Work is guided from the Leagues headquarters in Helsinki and from 13 independently operating districts. Funding for the Leagues activities comes from membership dues, private donations, and government grants.

Mothers Aide (MODREHJAELPEN AF 1983) in Denmark: From 1939 until 1976 Denmark had a public Mothers' Aid Institution, admired worldwide. This program operated 14 Maternity Aide Centres located in the major towns all over Denmark. The object of these centres was to help pregnant women, married and unmarried alike, single parents and other families in connection with or after childbirth.

The centres provided personal, social and legal assistance to these women and families. Further, the centres ran special treatment and convalescent homes for mothers with babies, ran service flats for mothers alone with children and arranged summer camps for mothers and their children. The Mothers' Aid Institution was also able to grant assistance for training courses for husbandless mothers so as to enable them to provide for themselves and their children.

Through the Social Assistance Act of 1976, an effort was made to consolidate and better coordinate all these kinds of services by putting them into the municipal social assistance office available in every town. This lead to the closing down of separate organizations such as Mothers' Aid. However, in the 1980's it became obvious that many of the 276 social assistance offices did not have the time and/or expertise for individual counselling of mothers and children. In addition, unemployment and changing social conditions were putting more women at risk. Because of this, a new private charity version of Mothers' Aid was formed in 1983. Its objectives are to offer social, financial, and educational support to mothers in order to enable them to secure for their children a better adolescence and better living conditions and to promote legislation which provides for social and educational support to single parents. There is a paid director and secretary and 400 volunteer professionals who give four to 20 hours a week to service. It is hoped to have at least one paid position in each major city. Mothers' Aid is governed by a board of directors of nine prominent citizens including representatives from industry, trade unions, and professionals. The current board chairman is an elected national legislator who knows the political system.

Programs:

1. *Free consultation* is provided about a variety of problems including financial, legal, health, relationships and career. Volunteer professionals are available evenings and include psychologists, lawyers, midwives, social workers, and teachers. Volunteers give four hours per week to staff these sessions.

2. *Drop In Coffee Houses* are provided to combat loneliness and isolation in big cities. These are places were one can go to socialize, prepare meals, swap clothes and toys, and learn domestic arts such as sewing.

3. *Emergency housing:* six flats are available for up to six months for mothers with an unstable living situation.

4. *Summer holidays:* special holidays are arranged for worn out mothers and their children. Many of the mothers seen have not been on a holiday for years. The organization provides for rental of summer houses available for 1-2 week vacations for single mothers with children.

5. *Summer programs for children:* four weeks of half day programs of artists, dancing, games, etc. are available in some areas.

6. *Preparation for vocational training.* Many of the women in contact with the Mothers' Aid Institution have but minimal levels of education. Those who have employment are almost all unskilled workers. To bring these women up to a point where they can benefit from future vocational training a 16-week preparatory course is offered periodically.

Social Marketing: To facilitate public relations and fund raising a companion organization has been formed across the country with 20 local communities and about 3000 members. These local organizations also assist the counselling centers in integrating and involving the mothers in local communities.

Publicity is facilitated through board members with newspaper, radio show, and political contacts. The womens group of the Lions Club also arranges for speakers to inform Lions Club members around the country of its program and needs. Once a year presentations are made to the social affairs committees of each political party. Finally, publicity is obtained through a variety of local fund raising events.

Evaluation: A special group of researchers has been formed with the responsibility for documentation and evaluation. It consists of sociologists, statisticians, psychologists and physicians. In 1984, 1,433 women asked Mothers' Aid for assistance. Most of the women were single and 80% were between 20 and 40 years old, with only 5% under twenty. Thirty percent were living on social welfare benefits and only 20% had more than a basic school education. The main problems for which aid was sought were financial, housing, and relationship problems with children and/or ex-husbands.

Radda Barnen: The Swedish Children's Ombudsman: Save the Children (Radda Barnen) is involved in projects world wide but also works as an advocate for children in Sweden. The aim of the Children's Ombudsman is to be a spokesman for children who can put pressure on decision makers as well as supply knowledge to parents and professionals to help them meet the needs of the children they work with.

"The Children's Ombudsman is not a single person, but there are altogether five who are responsible for different areas. One ombudsman works with immigrant and refugee children. Twenty years ago we had hardly any immigrants in Sweden and yet in 20 years from now, every fourth child will have an immigrant background. Radda Barnen arranges seminars, debates, lectures and other activities to increase the knowledge among native Swedes about the refugee and immigrant children' backgrounds and needs."

Another ombudsman works with children in day care, children and peace, and children with self-destructive behavior. The third ombudsman is responsible for children and violence in mass media, handicapped children and children in hospitals. The fourth ombudsman takes care of questions concerning children in foster care and how new family patterns influence the lives of children. The fifth ombudsman is responsible for child abuse/neglect and children's rights.

The aim of work can be summarized in six different points:

"(1) To strengthen the legal rights of the child. One ombudsman is a member of the Swedish Committee on Children's Rights of the Child. Most proposals from the government and committees that deal with questions that have anything to do with children are referred to us for consideration. In that way, we are able to influence the government and the Parliament. We also endeavor to influence public opinion in these matters.

(2) To spread information about children's needs and rights to decision makers, professionals who work with children, parents and others. This is done through information material, mass media and frequent lecturing. Once a year we publish a book about our most recent work.

(3) To organize seminars and do in-service training for professionals who work with children, especially in areas where we think the central or local government is not doing enough, such as child physical and sexual abuse.

(4) To support research about children and their situation. We invite the researchers to present their findings every spring at three "Children's Days" in Stockholm. About 1,500 professionals participate each day. During the fall, we do the same program in four or five cities in other parts of Sweden.

(5) We have a telephone advisory service for individual cases. Both professionals and ordinary people call us. There are primarily three different types of questions that dominate this service:

(a) People who are worried about a child call and want to have some support to either report it themselves or they want us to do the report as they prefer to be anonymous. Some children also call and want help. When they do, they are usually desperate and need immediate help.

b) People call to get support from someone outside when a decision or a suggestion from a local social board goes against what they think, right or wrong, is best for the child. We can be someone to discuss the case with, give information about the legal possibilities and rights, and when we find it suitable and necessary, try to persuade the authorities to change a recommendation or decision.

c) In conflicts about custody, it is normally the parent who feels wrongly treated who calls us. Our role is mainly to listen and inform about what legal rights children and parents have.

(6) We carry through projects both to try to change people's opinion and to work out models that others can use. Last year, we interviewed 50 children in foster care about their feelings and experiences. We hope that the results from the project will lead to improved conditions for foster children. We have also had several projects concerning violence in mass media and its influence on children.

As Children's Ombudsmen, our main aim is to improve the society so that every child can grow up in a good environment and be able to develop into a harmonious adult. To get there, we have to give priority to children and children's needs and see children as a positive resource."

BRIS: Another advocacy group for children's rights in Sweden is BRIS. This group came into existence in 1971 after a lot of publicity about a three year old girl who was battered to death by her step-father. In 1972 BRIS started a telephone service so that people could have someone to talk to about children they knew were being badly treated. In 1980 a Children's Help Telephone was started with a number only children may use. The majority of children who call are between 10 and 16 years of age. The most common problems are connected with parents divorces and conflicts between teenagers and their parents. In 1985 a Children's House was opened in Stockholm as a place where children could come to get help with problems. BRIS also does extensive public education about the needs of children and parenting through publication, seminars, and parent groups. They have also been involved in passing legislation such as that prohibiting corporal punishment.

RESULTS FROM COMMUNITY WIDE APPROACHES

All three Scandinavian countries visited employ a community wide approach to promoting the health and development of families and young children by providing an array of parent and child health, education, and support services. If our hypothesis is correct, these programs should result in a decrease in the incidence and/or prevalence of the types of health and developmental problems we have identified as being associated at least in part with family dysfunction: as related to birthing and parenting behaviors and skills. Other useful indicators are measures of provider and consumer satisfaction and costs of services compared with benefits. Information obtained on these is as follows:

Birthing and Parenting Behaviors and Consumer Satisfaction:

1. *Early and Regular Attendance for Prenatal Care:* Generally, at least 95% of mothers in these countries start prenatal care before the end of the fourth month and nearly as many have a post partum visit. In the U.S., less than 85% of pregnant mothers have entered into care by this time. (Wynn and Wynn, 1979 (a)

2. *Age at Birth of First Child:* Less than 4% of mothers are under 20 at the time of births of their first child whereas in the United Stated, the average is close to 10%. (Jones, et al 1986)

3. *Abortion Rate:* "While the U.S. abortion rate is lower than that found in any of the Eastern European countries or in Japan, it is higher than most other developed countries. In 1983, there were about 27 abortions per 1000 U.S. women between 15 and 44 years of age inclusive, compared to 18 per 1000 in Denmark and Sweden, and 12 per 1000 in Finland." (Henshaw, 1986)

4. *Utilization of Well Child Programs:* In a random sample conducted by the Institute of Social Research of Denmark, it was found that: "Health visitors have called at 98% of the homes of all children. The extent and regularity are determined very much by the health visitors, depending on the actual need of the individual family and on capacity. In the case of about 50% of the families interviewed the health visitors had stopped when the child was about 1 year of age. In close to 30% the health visitors had continued to call after the child's first birthday and in 20% the visits had stopped earlier than a year. Regardless of when the calls had ceased, a considerable number of families wished that the calls had continued. This applies to about 30% of the families in which the calls had stopped when the age of the child

was about 7-12 months, but to about 50% of the families where the calls had stopped earlier or later. No noticeable differences were found with regard to contributory factors between families wishing the visits to continue and other families. It is a very small number of families who have not attended the prophylactic health examinations of their children or been visited by a health visitor. Thus, there is no evidence of aversion in the population to the offer of prophylactic health care for young children." (Danish Institute for Social Research)

In Sweden, there was more demand for specialist care so that pediatricians and obstetricians' staff about one third of the prenatal and well child care programs.

Provider Satisfaction:

Information on provider satisfaction is only anecdotal. All of the five or six general practitioners that I talked with were enthusiastic about their job and had a strong interest in prevention. Because of the nurse home visitor, and social service backup, they felt they could deliver a high quality comprehensive service. The hospital specialists were not so enthusiastic particularly those just starting out. An excess of physicians in each country was making competition for the limited number of hospital positions intense and there was actually some unemployed physicians in Denmark.

In Sweden, the community based pediatricians and general practitioners were in a power struggle for control of the primary care system with the general practitioners appearing to be gaining the upper hand.

Health and Development Outcomes:

1. *Infant Mortality and Births of Low Weight Babies:* As previously discussed, these are among the lowest in the world and even surpass those of states such as Maine, New Hampshire, and Vermont which do not have any large ethnic minorities or big cities that complicate the delivery of care.

2. *Deaths from Diarrhea and Pneumonia:* The frequency and severity of these conditions have been related to family functioning and access to health care. Death rates for these conditions are much lower in Scandinavia than the U.S. One might infer from this that either fewer infants end up in the hospital with these conditions (most likely) or their treatment is better than in the U.S. (least likely).

Deaths per 100,000 Live Births for Respiratory and Diarrhea Diseases During the First Year of Life (1974)
(From Wynn and Wynn, 1979 (b))

	Respiratory	Diarrheal
Sweden	22.2	3.9
Denmark	32.2	13.9
Finland	65.6	1.6
U.S.A.	107.3	21.6

3. *Dental Caries:* All these countries have put into operation, an extensive program to prevent caries. School health physicians in practice ten or more years all noted a dramatic decrease in the prevalence of dental caries following the institution of these programs. This was well documented in Sweden. In 1960, a nationwide health and developmental examination of four year olds, showed that about 74% had caries and 20% gave a history of having had to receive emergency care for an acute dental problem of some kind (infection and/or trauma). In the seventies, this had fallen to 30% with caries and only a "small number of emergencies." (Holst and Kohler, 1975)Similar results are reported from Finland. (1986)

4. *Rates of Child Abuse and Neglect:* Accurate data for both the U.S. and Scandinavian countries was difficult to come by. In Scandinavia, everyone I talked to felt that examples of severe physical abuse were now quite rare. I was able to find a few published studies to back up their impressions. In an article by Christoffel, Lui, and Stanler (1981) on the epidemiology of child abuse it was reported that specific death rates per 100,000 population for definite and possible inflicted injury, for Denmark, Finland and Sweden are about 8 times lower than the U.S. for children under one, and between one and four years of age. Homocide rates in general have also been shown to be lower in these countries than in the United States though suicide rates are higher in Scandinavia. (Rosenberg, M.; et al)

Corporal punishment by anyone including parents is actually illegal in Sweden. In a study of hospital admissions reported by Tletjen, (1980) it was found that only 10 children nationwide were admitted because of physical abuse during a one year period. On the other hand according to medical and social service personnel I talked to, child neglect and sexual abuse are still fairly frequently encountered. However, no one I talked to had ever heard of sexual abuse occurring in a day care setting, such as has been frequently reported in the United States.

5. *Speech and Language Development:* For those countries with a scheduled developmental exam at age 3, 4, 5, or 6, the percentage of children thought to be delayed enough in speech and/or language development to require therapy could be used. However, some measure of degree of severity also needs to be added. In one Denmark community that I visited less than 3% of seven year old children were thought to require some form of speech therapy based on a school entry exam but in Finland where speech therapists work in the maternal child health centers as many as 25% of the children under seven were thought to be able to benefit from speech therapy. The large majority of these were classified as mild articulation defects. In Sweden, it is estimated that about 10% of children in day care will need special services because of physical or social handicaps and centers are given an extra allowance to cover this.

6. *Mild Mental Retardation:* An epidemilogic survey in a large city in Sweden reports a prevalence of severe mental retardation in childhood of about 3:1000 compatible with rates of severe mental retardation in the United States. On the other hand, the prevalence of mild mental retardation was about 4:1000, eighth or ten times lower than rates reported in the United States. In addition, the proportion of children falling in this range with signs of prenatal or perinatal origin was much higher. This suggests that the reduction has been in the proportion thought to have a significant environmental component as a contributory factor. (Hagberg et al, 1981, Sameroff, 1986). In New Hampshire, in some communities, as many as 30-40% of children eligible to enter first grade are thought not to be ready for a regular first grade curriculum and another 25-30% need special services (special education and Chapter One) after entry into first grade.

COSTS

In spite of (or because of) providing comprehensive subsidized health service, expenditures for health care as a percent of the gross national product are less in the Scandinavian countries than in the United States. (7%-10 vs. 11%). The percent of GNP spent on social services is greater, however. The total amount spent on health, education, and social services varies from about 25% of GNP (Finland) to 35% (Sweden) in these countries as compared with 18% for the United States.

About ⅔ of program costs are related to personnel salaries. General practitioner salaries averaged around $54,000 in Denmark. In Finland, a basic salary for a 36 hour week was about $24,000. This could be supplemented by about $10,000 working longer hours at a set rate or up to an additional $36,000 by private practice. Basic salaries in Sweden for general practitioners were about $35-40,000 with similar options for increasing the amount. Public health nurse salaries averaged about $12-16,000 per year in Finland and Sweden. Midwives in Denmark made up to $24-25,000.

Some reasons given for lower health care costs in spite of providing substantially more services are:

(1) Strong orientation toward prevention

(2) Provision of most preventive services by persons other than physicians

(3) Primarily per capita reimbursement mechanism rather than fee for service

(4) Overall Coordination and Planning: Priorities are established for a fixed amount of dollars. Money for heart transplants must compete with money for primary care health services

Although tax rates are high in these countries (40-50% of average full-time employee's income) per capita disposable income (8,000 U.S. 1975 for Denmark) is one of the 10 highest in the world. In Denmark 23% of income is spent on food and drink, and 17% on housing. Fifty percent of Danes own their own home. Ownership of cars, color TV, refrigerators and telephones is high in all countries.

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DISCUSSION FOLLOWING PRESENTATION

(*Chamberlin*): One of the things that's very different in these countries is they don't talk much about cost effectiveness. The services are provided because they see them as important support systems for families and children. I get very impatient with people who say, well, it's not proven that this works or not proven that that, works. How many times to do you have to show that doing this is important? There are now good studies that have shown drop-in centers can provide support to parents and they can provide development promoting environments for kids. You can say the same thing for home visitors, school-based programs for adolescents, development promoting day care and preschool programs, and youth programs. There's adequate data to show that these programs are important. What needs to be done is to look at what is the best mix for a specific community and how to organize and coordinate them. The politicians generally don't read the studies anyway so it's more a matter of political will than a lack of data showing that these kinds of services are important. All the parent support programs in this country have to spend large amounts of time in fund raising which I think distracts tremendously from energy that could be put into program implementation. Somehow we need to develop some basic stable long term funding for all of them.

How could we do this? Several things have been mentioned. There's the block grants, and getting agencies who are spending all their money on treatment to contribute 5% or 10% of their budget into a pool that local communities can apply for to start some of these kinds of preventive programs. That's one strategy. A trust fund has already been mentioned where there's a check off system available as a way of getting money into it. Again, this provides a pool of money that local communities can apply for to develop these preventive programs. Another is a line item budget provided by legislature. We'll hear this afternoon about some statewide programs that have been funded by line item budgets. However, it's clear that if you're funded by a line item budget you have to build in an advocacy system to keep it, otherwise, it will disappear at the first sign of a budget crunch.

The other thing that I see as important is to try and establish a data base. We were talking about how you would identify communities in need of more programs and I think it is important to get some broad-based indicators of family functioning that indicate whether or not a community is in need of more services. Rates for child abuses and neglect are important ones, low birth weight rate is another important one, and the number of kids coming into school systems that lack school readiness would be another one. What I find at the State level is that this information is all in different agencies and broken down into different age groups so you can't compare rates. It's a big hodgepodge. What needs to be done is for state agencies to get together and decide how they're going to look at communities and develop a few basic indicators that every agency can use to determine when this community needs more services.

I see the state as a facilitator to help local communities establish programs. They need to have the capacity to provide technical assistance in social marketing, training providers, interagency collaboration, and local fund raising. The energy has to come from the local community but the state plays a very important role in terms of facilitating that process.

(*Berry*): What are all the reasons for the high suicide rates there?

(*Chamberlin*) Nobody seems to have a clear idea. Those countries are depressing in the winter I can certainly vouch for that. They're cloudy, cold, and damp and that's one of the causes that people say. Whenever I give this talk, that's the first thing everybody says, "Oh, look at their high suicide rate." However, they don't seem to know about their low homicide rates. It's clear that they haven't solved all their problems. They have high divorced rates, and a lot of single parents, but they've got the support systems built in so that the families don't break down. At first, I was naive enough to think, if you have all these services, you ought to have lower divorce rates but it does not seem to work in that way. However it does work for the kids. If you plug in these kinds of services, you can significantly reduce morbidity and mortality in young children.

(*Weiss*) I can't remember which country it was, but I think it was Denmark. You mentioned that their services for young children were purposefully organized through social services because there was a feeling the educational system wasn't as responsive to families. A lot of the examples you've given from those countries seem to be around health and social services and you've mentioned very little about education. In this country, a lot of the thrust now is toward organizing services for kids around the school system. That's a prime example of a counter kind of notion. Would you extrapolate from the Scandinavian example that we ought to be putting our resources into non-school based things.

(*Chamberlin*) Yes, the feeling in these countries is that social service is much more tuned into families than are school systems, especially families with young children. This would agree with my admittedly limited experience with schools in this country as well. Some encourage family participation but most do not. Most of them do not want to get involved with the families because they're hardly surviving in what they're trying to do now in educating kids.

(*Weiss*) Another thing you talked about was interagency coordination, would you have the school as a player in the system, if not the dominate member?

(*Chamberlin*) Well, in Scandinavia there's a school nurse that does the coordinating in the schools when the kids get to be seven. The school nurse also works for the town and she has access to the social workers and all those support systems and they meet periodically. For example, in Hoelbek if any child got in trouble with the law, they would get the school, the social worker, and the family together and sit down and look at that whole system and try and figure out what was wrong and what was needed. So yes, the school should certainly be a player.

In terms of family support, one of the most striking differences in attitudes, is that instead of seeing everyone as a potential welfare cheat they see welfare recipients as persons with needs. If they see a single mother with 3 or 4 kids who hasn't had a vacation for a couple of years, they'll pay for her to go two weeks to a resort either with or without her kids because they feel that that helps her cope. That's an entirely different way of looking at things than in this country.

(*Mitchell*) Can you account for that? Where has that difference come from? Who changed that attitude? How come we don't have it and they have it, and how can we get it?

(*Chamberlin*) I think, at least in my state, where our motto is "Live Free or Die," there's a strong individual freedom ethic which says you ought to be able to function without all these services, and if you do get into trouble, it's probably you're own fault. I think it's that part of the protestant ethic that says if you're virtuous and work hard, you'll be all right and you don't need any kind of government support. If we look at our health programs, most are targeted toward high risk individuals, there's very little that is targeted toward communities as a whole. Things are seen as an individual problem, not a community problem, or a family problem.

(*Berry*) Do you think the emphasis is changing? When I went to Minnesota, I was struck by the very nice neighborhood nursing homes for the elderly in every little town.

(*Chamberlin*) There are a lot of Scandinavians in Minnesota.

(*Berry*) Right. And I wonder if it's related to that ethnic background.

(*Chamberlin*) Probably, in Scandinavia there is a parallel support system for the elderly. They have drop-in centers, transportation, subsidized housing and recreation programs in most communities. Maybe Dr. Papiernik's theory is correct that when all of this was developing in Europe, we were in our isolationism phase and not associating with Europe. I've never heard that explanation but it's fascinating that during that period of isolation was when a lot of these services were being developed in European countries.

(*Weil*) I tend to agree with you about wanting to see these services for young children in the community as opposed to being in the schools. However, the one institution we seem to have accepted in this country for children is the public school. They're not very well equipped philosophically or programmatically, I think, for services for young children and families. However, psychologically, that's where we accept turning over the children and moving away from that independent 'I can take care of my own and don't need any help' and so on. Once children are of school age, we assume, except in New Hampshire where you don't have kindergartens, that's an appropriate move. We've accepted that over a long period of time and I'm wondering if anybody here has any thoughts about how we can move that acceptance of services to those for young children. We want it to be more community wide but we want to institutionalize the acceptance of the idea that it's o.k. for younger children and families to be served by a whole range of services in the same way that we accept when kids turn '5' they're going to go off to school. How did that cultural acceptance come about in our country and what might be the mechanisms for moving our thinking and the thinking of large numbers of people to that acceptance of programs for younger children and for families.

(*Albano*) Well, I think, with the movement toward single parent families and/or the two worker families, people are relying on teachers to really take care of their children's educational needs, so they're seeing a value in their teachers again. And, I think, the same thing is leading toward the development of the school based wellness clinics, and an emphasis on health care in the school that has emerged over the last 5 to 6 years. Now you're starting to see a new recognition of the role that the nurse has in the health care provided in the school with back up from social service and other support systems there. So, I think, that's what's happening is the American culture. I think a big difference in the United States, is that we're very concerned about the dollar, making it and accounting for it, which separates us from the Europeans. Also, World War II mentality, they're reconstructing, we're making money. And I think you're going to see a new emphasis on nurses in schools and a higher degree of reliance on that by families who use that as another resource to assist the family.

(*Weil*) And do you think that there's going to be an increased acceptance of child care personnel as this expert level of people that we can turn our kids over to in the same way we trust the school?

(*Albano*) I think you're seeing it at least in New Hampshire. Concord, has increased their school budgets for teachers by 30% over a two or three year contract. It seems as the family breaks down, we're relying on others to take care of kids and the schools are going to be one and day care is going to be another.

(*Chamberlin*) I've been in New Hampshire a little over three years. The first year the legislature was all upset because they had to find money for more social workers because the child abuse rate has increased about six fold in the last 10 years. The second year there was a great big hubbub about all the money needed for special education because they were finding so many kids who needed special services. Last year, they were having to find new money for more jails because of increased crime rates. Not once during that whole discussion did anybody mention spending any more money on prevention. That's where they're at. That's why, I think, we needed social marketing in this state if we're going to get anywhere because the legislators don't see that we could be preventing many of these problems.

(*Weiss*) I wanted to address the school based question in the sense that it seems to be one of the things that Dr. Papiernik said is pertinent here as well, and that is that it takes time. Were talking about a shift over a fair amount of time and attitudes towards what schools should or should not do. There are now a couple of significant state initiatives that have State school systems providing services, in some cases prenatally and on through the first 6 years of life and that's a real shift. The project that I work with has been looking at school based family support programs from the 0 to 6 year age group. There are more and more of those occurring around the country. What's ironic is that when you talk to the directors of those programs, they will tell you that they are very fragile add-ons to a school system, and that often their support comes from the larger community, the non-school based people. It's a struggle every year for money but they survive and their little total is getting to be, you know, from the baby toe to the next toe at least. So I think we're looking at a shift in attitudes that's going to take a lot of time. I think the larger question is one of, now that we have a window of opportunity to do some things for this age group and the population, where does one put these programs. And I'm not thinking of it in terms of a single institution. I think you can make arguments against schools. I can make arguments against health care providers as being responsive to families, I can make arguments about social services, and, I think, they have all their pluses and minuses. I don't think it's a question of 'in an institution'. I think it's a question of coming up with some kind of model that will maximize the positives of a variety of institutions working together at a community level.

So it's changing the nature of the questions. And I would say the school should be a player, in some places a major player, in some places a minor player, but there should be an opportunity for them to be a player when it's appropriate and the same thing with social services, and health care providers.

(*Albano*) I think they should be a major player because, at least in the school based clinics that I'm aware of, and I think there are 50 or 60, now across the country, what they've produced so far is measurable. They've been able to keep kids in school longer which has other important social ramifications, and they've been able to reduce the rate of teen pregnancy. However, the ones that are very sensitive to the communities, don't tackle reproductive health in the school, they do it across the street in family planning clinics. So you're bringing in your other social resources which is good but it misses a lot of those other pieces that I think are critical also, but certainly I feel the school is a major player.

(*Weil*) If you look historically at a community, about the way things have happened, it often starts off with targeted programs.

For instance, in Maine those coordination systems that I keep talking about. There are, I think, 22 schools that are providing services to preschool handicapped children. A high proportion of them are doing it because there were one or two very innovative people 8 or 9 years ago, within those school systems or within those communities, who happened to get programs started that are located in school and have a fair amount of school support. Most of the services in Maine are not school directed. But I would not want to get into a big fight in Maine about whether they should be in schools or not be in schools because the ones that are in school have tended to have some innovative leadership, and are doing a good job of coordinating therapies and a number of other things. To me it's not worth fighting that fight. We need all the help we can get from whoever is doing good kinds of work whether it's in a church basement or in an extra room in a school and we may be reaching the point in many states where we really desperately need those extra rooms in schools for some of the kinds of things we want to do. They're not going to be there with our demographics going the way they are. It's a debate that I think early childhood people are letting themselves fall into, that I think is a dead end.

(*Chamberlin*) I think it's obviously going to be a pluralistic system that's going to be different in each community.

(*Pierson*) Just briefly to concur in what I think the route is to follow. You need a collaborative approach but to rely upon the capability of the lead agency. Two years ago I attended a three-day conference in Minnesota. The aim of the conference was for policy planners across the country to develop a consensus among day care providers and school personnel around who should be the lead agency in providing quality child care and early education. It started with very persuasive presentations on the values of each and then fell apart. There was no consensus at all. And, you know, this afternoon I'll present a model for school base education but I think that so often we've found that there's no single solution and the harder you try to push for one solution at this point in time, it's probably not going to work.

(*Mitchell*) In the Scandinavian system you were saying part of this issue is how do you balance community controlled and developed programs with that set of minimum standards, whatever that is. If you're looking at the new birth to 3 or birth to 5 money, clearly there are federal guidelines attached to it. The lead agency doesn't have to be, education, doesn't have to be health, but there has to be a lead agency. How do they do that in Scandinavia? I mean how intrusive are those or how supportive are those minimum guidelines?

(*Chamberlin*) Each community has an elected council and from that council they form a subcommittee on health and welfare and that subcommittee is what oversees all the programs for families and kids in that community. If somebody has a complaint, they go to that committee, if somebody wants to introduce something, they go to that committee, so that's how the programs are supervised.

(*Mitchell*) So it's comparable to Christine's council, the health promotion board.

(*Chamberlin*) Except it's elected. It's made of elected representatives who then get help from professionals.

(*Mitchell*) So the decision makers about family services in a local community are not a social service and education types necessarily but a board.

(*Chamberlin*) I think so. The day to day administration is by employed administrators and social workers but they're answerable to the elected committee that oversees them. It's interesting, New Hampshire has town meetings for all their towns. I live in a town of 1600 and we're redoing our five-year plan and so I thought, well, let's practice what we preach. So, I said we ought to look at what's happening to families in this community, and I went around and interviewed a lot of the elderly, some single parents, and working parents, and this sort of thing. I came up with a list of things and one was that we ought to form a committee to look at what's happening to families every year and have it part of the annual report. It's now in the mix and whether the selectmen will include it or whether it's too radical for the community I don't know. We're just not used to having somebody look at what's happening to families in the community as a whole.

(*Weil*) Partly in response to Cheryl's thing about what we can or can't do in relation to guidelines that are set. I think the new federal legislation, 99:457, that you're referring to, I don't know if it allowed for an interdepartmental lead agency within the language, but Maine is a state, and I think Texas is another and there may three or four others, that chose to apply for an interdepartmental council being its lead agency. So in our state, it's the interdepartmental coordinating committee for preschool handicapped children which we call ICCPHC. And that is what's accepted by the Federal government as an o.k. lead agency, so we got away from having to be health or having to be education by either asking for a waiver or assuming that we could do that and doing it and then the Federal government had to respond and they responded positively. I don't know the legislation well enough to know if it was already allowed.

(*Bauer*) I think it was required that they be an interdepartmental group the legislation is quite clear on that.

(*Weiss*) It is required but I think you're making a different point and that is that your lead agency is not what we think of as an agency but rather an interagency coordinating council acting as a lead agency.

(*Weil*) And we went to our Attorney General in our state to see if this interdepartmental committee could have the state authority to be a lead agency and got word back that yes, it could, and so the funding is going to come to it to administer.

(*Chamberlin*) Are you incorporated as a separate group or anything?

(*Weil*) No.

(*Chamberlin*) But you still get a budget and you get a bank account?

(*Weil*) The State budget that we have is designated to go to this interdepartmental system. The money actually gets spent by our Dept. of Education but it is this interdepartmental council that has authority over it and the Dept. of Education has really given up its authority over those funds in quite a remarkable way I think.

(*Berry*) Does Scandinavia have an educational philosophy that children under 7 ought to play more and have music and be outside?

(*Chamberlin*) Yes, the people that work in the centers are people that have had three years of early childhood education and they see this as a development promoting environment. They do try and promote play and rhythm and music and things like that.

(*Berry*) I'm not an educator so I don't know, but I presume it's like every other stage of education with different theories.

(*Chamberlin*) They're not learning ABC's and 1 and 1 is 2, they have a strong feeling for emotional and social development as an important part of the curriculum.

(*Berry*) Thats one argument for separating it from the more formal education system. But do they support the arts? It sounds like they certainly support health services in school. In other words, when the school budget goes, usually physical ed, music, and health go first, is that the case?

(*Chamberlin*) I didn't really get into the regular school system enough to answer that question. They certainly have it in the preschool programs, the arts are a big part of the curriculum.

(*Bauer*) To change the subject over to the health aspect of the home visitor part that's present throughout Scandinavia did you get a sense as to what it was in the tradition that makes this universally acceptable, to have somebody coming into the home on a regular basis.

(*Chamberlin*) It differed. In Denmark, they started off with, three pilot communities and tried it out and, as I understand it, infant mortality dropped in those communities. I don't know how solid that data is but that's what they say and then it was offered to everybody in the country. That was the way it was introduced. It's all voluntary. You don't have to have a home visitor come into your home but something like 95% of the mothers use it. In Finland, they made a deliberate policy decision in the thirties to emphasize maternal-child health because they had such a high infant mortality rate. They introduced these community centers and infant mortality came down. At the same time that infant mortality was falling, there were very high death rates for tuberculosis, heart disease, and accidents in adults. Because of this it seems to me it's fairly clear that these programs did have something to do with this improvement in maternal-child health.

(*Bauer*) Do they all share a common agenda as to what their program is, or what the permitted agenda is? Are they strictly for health supervision or health education regarding the pregnancy or the child or is it for general support or advocacy?

(*Chamberlin*) It's evolved. It started off fairly health oriented and it's now much more developmentally oriented. The public health nurses, after they graduate from nursing school, have to have a year or two of experience and then they go back for a year of training in maternal child health. From what I understand, that training has shifted more to emphasize developmental issues. The Mannerheim League in Finland has been responsible for developing a whole parent education curriculum. They've attempted to make them much more developmentally oriented. Now the midwife and the nurse in these centers are having group sessions with parents. They've had to take extra training in order to be able to run those groups. The content emphasizes emotional issues and developmental issues as well as health issues. In Finland there are very few home visits compared to Denmark. In Finland, almost all the contacts are in the center. They may make only one or two home visits during the whole first year, unless there is some kind of problem. In Denmark there are no centers so it's all home visits during the first year. Sweden is somewhere in between. So the emphasis on the home visiting differs quite markedly from one country to another.

(*Mitchell*) When you were presenting the population figures of a day care center for every 3,000 people and one maternal child health center for every 4,500 is that adequate? I mean, do you feel like the country is covered. And do the day care figure include the system of neighborhood homes?

(*Chamberlin*) There's never enough day care, they always tend to be a little bit behind. Their feeling is that the public cannot supply total day care to everybody. They're are church groups and other private groups. Access to care is on a priority basis and the people who are low on the priority list are physicians. I talked to several women physicians who were way down on the priority list and have more problems finding day care because they are economically well off and they live in good conditions. The ones who are high priority are the students who are in school, the single mothers, and the low-income working mothers, and they usually fill up the subsidized slots. The other mothers have to do it like we do and find people in the community to take their child. However, I think, that anybody that takes their child is then supervised from the local office in terms of content and what's happening in that environment.

(*Mitchell*) Do you then have a stratified system where there are subsidized slots for the low-income working families and then private expensive preschools for the more affluent?

(*Chamberlin*) It's done on the basis of need not income. Coverage depends on the area. The cities now are behind in child care facilities because there's been a massive migration from the country to the city and the immigrants from foreign countries are coming in so they don't have enough child care for everyone in need. In some of the smaller rural communities, they have enough places for everybody, it varies in terms of what's happening to the population shift.

(*Mitchell*) And the home providers, are they mostly infant care? Do they also do preschool care?

(*Chamberlin*) They do both. Most day care centers have a toddler group, a preschool group, and an afterschool group. And there are some mixed age groups that simulate sibling interactions.

(*Weiss*) It seems to me that some of the people in this country who have looked at day care for example, at the policy level, have found the argument to look at what the Scandinavians do or look at what the other modern industrial societies do, creates a backlash against always being compared to those countries on these kinds of services. I'm curious, you're now moving out beyond child care and looking at systems of services for families. I wonder how one sells what your selling, whether one emphasizes at the top that this is what other countries are doing or emphasizes the model that says, Oh, by the way this is being done in the Scandinavian countries, and I'm curious about your thoughts about that?

(*Chamberlin*) I don't know the answer to that. That's one reason I wanted social marketing people here so we could look at how they go about selling these kinds of programs. I gather, if I've learned anything, you have to find out where the community is and tailor the message in a way that they can relate to it. I haven't learned to do that very well yet and I think that's essential to get it across.

(*Albano*) We've just had an example of what Heather is talking about. I mentioned yesterday the infant mortality report that was produced a year ago. Even within the Division of Public Health that rection came also to: "Look what Scandinavia does." Our infant mortality rate in 1984 was 10.2 and a number of us thought that was terrible and as soon as we said, look what Japan does their reaction was well, that's Japan. But when we noted that Georgia and North Carolina had separated the black population from the white population and had better rates for whites than in New Hampshire that struck home because that was in the U.S. So maybe part of the answer is to find out where it works someplace here and say, well, if we can do it in New Mexico we can do it here. However, if we compared ourselves to Massachusetts, then they'd throw us out the door.

(*Wallner*) One thing you want not to do is be compared to Massachusetts but if you want to be compared to Vermont or Maine, that's o.k., Iowa, that's all right, but not Massachusetts.

(*Chamberlin*) Mary Jane could you tell us what your thoughts would be on how to sell these kinds of programs to the New Hampshire legislature. How would you package it?

(*Wallner*) I think that from what I've heard in the last day or so, I really think that you have to look at one issue at a time and, you know, the social marketing people were saying go for the one issue at a time. I think that at least from my experience in the legislature, that's what people need to have, one thing at a time to deal with.

(*Chamberlin*) So how do you keep from getting it fragmented? That's the problem with the one issue approach?

(*Wallner*) I'm not exactly sure. Obviously you need a master plan at some point but I think you really need to take one thing at a time and introduce that and not try to overwhelm them.

(*Chamberlin*) What if you got the governor to set up a task force on what's happening to families in this state. Is that a feasible way of doing it?

(*Wallner*) No.

(*Bauer*) We had one of those in Maine and that's pretty broad.

(*Chamberlin*) Would you say that child care is a big issue then or housing, or what issue would you pick to try and get across?

(*Wallner*) In New Hampshire, I definitely think that housing is a really big issue.

(*Chamberlin*) More than child care.

(*Wallner*) Yes I think the child care issue is also a big issue but not because there's a lot of concern about our children right now but because we have an economic situation in New Hampshire where there's a labor shortage and politically they're looking for people to work and to get into those jobs.

(*Chamberlin*) So, you present it, in economic terms. We need housing and day care in order to get people to come and work in our companies?

(*Weil*) Developmentally one can argue it's just as well for children to not start school until 7. You might want to say, figuring that public kindergarten just may not be a battle that can be won in New Hampshire given your tax base, what we need are developmentally appropriate child care services for all these children of two parent or single parent working families. If we're not going to have public kindergarten, let's have good quality child care programs so that children are getting adequate developmental stimulation and they'll probably learn to read just fine at age 6 or 7 when they do start school.

(*Chamberlin*) One of the problems with no kindergartens, is that all the Head Start programs are filled up with 5 year olds. I can't find any Head Start spots for 3 and 4 years olds.

(*Wallner*) It impacts the day care system also. We're literally serving more children in New Hampshire because we have to serve them for that extra year because there are no public kindergartens.

(*Bauer*) One response to the fragmentation issue: I guess one of the messages I'm starting to get is that one does it in little pieces at a time. You're more likely to succeed if you have a fairly concrete piece, and that piece may be different from one community to another or one state to another in terms of what capabilities there are or what interests there are, and what resources are there. So it almost seems inevitable that there will be a degree of fragmentation in terms of how these things come on the scene in America. We aren't going to implement the full Scandinavian model for instance. It's nice if that could be, but it probably won't happen. The reduced fragmentation, probably would come after the fact when programs are in place. Then you could set about trying to have tasks force to integrate things or get coordination and try to reduce the fragmentation. The other thing is that it may be that, with all the consciousness raising, the fragments that get in place will be somewhat better coordinated from the start.

(*Chamberlin*) Let me just welcome Dr. Zigler. Do you want to make any comments about the discussion?

(*Zigler*) It's interesting, we've wrestled with all these problems for a good number of years. I think I'll just wait. But you're right we're never going to have the Swedish model.

(*Mitchell*) I'd like to address it. Vermont got through a huge children and family services package last year without anybody perceiving it as a package of funding for children and families and now we are needing to deal with that coordinating issue. We funded separately a parenting education program, in home services, parent-child centers, an early education initiative, and a significant expansion of day care. We all talked together ahead of time and everybody felt comfortable with, o.k., you'll get this piece of it and I'll get this piece, and then once it's all in place we'll work together. But, in fact, because each one of those line items has a different set of reporting forms and a different set of evaluations, it has different ownership. The Children's Trust Fund is owned by somebody, the Early Ed Initiative is owned by somebody else, the day care is owned by somebody else. It does have the effect of fragmenting communities that, in fact, were doing comprehensive programs and felt very comfortable supporting each of these individual initiatives thinking all we need is the money and it will be no problem and we'll have everything. On the other hand, there's no way you could have sold a 3 and ½ to 4 million dollar package as a comprehensive family support system.

(*Chamberlin*) And then when you have to compete for the same money, that brings in a whole other sort of negative interactions.

(*Mitchell*) I don't know what the answer is, but I do know it's a problem and we didn't think it was going to be.

(*Weiss*) I was just going to say that in looking across the states most of the places that have gotten any kind of a substantial initiative going through a legislature have used a social problem approach, whether it's one social problem or a package of social problems. Somehow what you're doing is going to have to address that and that's seems to be the reality of it. Then, people have tried to work in some places on the fragmentation issue informally and then formally through the way they wrote their RFP's. In some cases there will be an agency that's going to do the initiative but they'll try and work with other agencies at least informally, if not formally, to get them to buy on and to help them pick the local sites that are going to do this. Then they write their RFP's so that they require interagency collaboration at that level. So that I think you may not be able to mandate from the top that this is going to be a non-fragmented system but there are ways to build in at different points things that will at least move in the direction of trying to increase some kind of collaboration. Maybe if we think of it in terms of what are some of the ingredients that can move it that way as opposed to just thinking it's going to happen or despair because it's not.

(*Chamberlin*) You can come in from the other way where the legislators get together and demand interagency collaboration by saying we aren't going to fund all these preschool programs unless all you agencies get together and came up with some kind of overall plan. So it seems to me that one of the best ways to do it is to get the legislature to mandate it.

(*Albano*) Cheryl, how did that happen in Vermont? Who pushed for the comprehensiveness of your budget?

(*Mitchell*) The advocacy group, the Children's Forum.

(*Albano*) That's right, like in New Hampshire where family planning and prenatal were the keys. That was the driving force, not the state agency and not the legislature.

(*Mitchell*) We also had key people within the legislature who had that vision of what needs to be happening comprehensively.

(*Albano*) Legislators who worked with the coalition which was the same with us.

(*Wallner*) But, you need the backup from the state agency. Just putting people out there and a state agency not providing information to the legislature doesn't work.

(*Albano*) Yes, we provided all the backup data.

(*Mitchell*) Technically the people in our state agencies are not allowed to talk to the legislature.

(*Wallner*) That was the message we got from the Maine legislator though wasn't it?

(*Weil*) Yes, that the message needs to go up to commissioner level people and that governors need to allow their mid level bureaucrats to talk with legislators so that they can fashion legislation that makes sense.

(*Berry*) Well, the mid level bureaucrats do in Vermont but it's not in an open way. The problem is it competes with the governor's agenda. The governor sets her agenda and she's not going to endorse other things that compete with it. But in Vermont, there was a surplus so it was trying to control exactly how those surplus dollars got spent.

Head Start and Legislative Approaches to Promoting Healthy Families and Children

Presentation by Edward Zigler, Ph.D.

(*Chamberlin*) This afternoon we have Professor Edward Zigler, Ph.D., of Yale University who is Head of Psychology at the Yale Child Study Center and Director of the Bush Center in Child Development and Social Policy. He was a member of the National Planning and Steering Committee of Project Head Start and was the first Director of the U.S. Office of Child Development and Chief of the Children's Bureau from 1970-72. During that time I was a member of the Child Development Section of the American Academy of Pediatrics and I remember a dinner we had with Dr. Zigler in Chicago. He was telling us about his political experience and all the criticism one has to take in such a position from various political factions. I asked him why anyone would want to subject himself to all that abuse. He responded that this is a place where you can make a whole lot of things happen. That's the trade-off, and we can all be glad that people like Dr. Zigler are willing to endure criticism and complaints if in the end they get to help children. Dr. Zigler is editor and author of numerous books and articles, one of which, entitled *Children, Families and Government*, is especially applicable to what were looking at today. I'm delighted to have Dr. Zigler here to give us his perspective on what we are trying to do.

(*Zigler*) I was asked to do one thing but I think I'd like to do two. One is to talk to you about Head Start, since I'm probably the oldest living Head Starter. But I also thought that for a group of this kind, especially in light of the discussions we just heard, you might be interested in some brand new developments in Washington. A number of policies for children and families are in the works right now, and if I were a state-level person I'd want to know about them so that the state can start planning and interfacing with the federal efforts as soon as possible.

Let me start with Head Start. My professional life has been intimately involved with this program, beginning when I was a member of its planning group some 23 years ago. Later I was the federal official responsible for the program during my years in Washington. In 1980 President Carter asked me to chair the

15-year Anniversary Committee on Head Start, which was given the charge of assessing the program and determining its future directions. Our suggestions were evidently lost because just a week ago I sat at CDF with a group who had come together to plan for the future of Head Start. At any rate, I am still very involved with this program.

I would like to put Head Start into an historical perspective for you because I think there is a lot to be learned from our experiences and our mistakes. As popular as the program is, it is a story mired in confusion and misunderstanding. I've been particularly intrigued by what I see as this nation's love-hate relationship with Head Start. The program started in 1965 and until about 1968 enjoyed a honeymoon period. The nation was euphoric over Head Start and praise was heaped on it from all sides. We were the Sesame Street of the mid-'60s. Then things went sour. In 1969, the Westinghouse Report appeared and proclaimed that Head Start produced no demonstrable, lasting benefits. At about the same time Arthur Jensen's monograph on the nature/nurture issue reappeared. This was a scholarly discourse on how much of intelligence is genetic, but for some reason Jensen began it with the phrase that compensatory education has been tried and it has failed. Pessimism set in around this time, and Head Start began to fall from its pedestal.

In 1969 I was asked by the White House to come to Washington to run the Head Start program among other things. Shortly after I arrived in 1970, an unnamed White House source was quoted in *U.S. News and World Report* stating that Head Start is a proven failure and is little more than a babysitting service for welfare mothers. To rub salt into the wound, the first week I was in town I was called over to OEO, which dispensed the Head Start funds. There someone from the Office of Management and Budget had put on the board a three-year phase-out plan for Head Start. So having been asked to run a program that was very dear to me, I arrived to discover that my real job was to close it down.

As you know, the program was not terminated. When I was in Washington, my strategy was to avoid a standstill by constantly improving and enlarging the program. My goal was to make Head Start into a national laboratory. We introduced a whole variety of programs within the Head Start framework. They weren't all booming successes, but some earned us a favorable reputation around the country. We started the Health Start and the Home Start programs, and we began the Education for Parenthood effort in this country. We began the Child Development Associate training program because we saw, as early as1970, that this country would soon face a tremendous child care problem. We had to start training a cadre of competent caregivers who could work at a price that parents could afford to pay. The program that I was most pleased with was called the Child and Family Resource Programs. The concept was to offer a collection of programs within a general setting where a family, instead of fitting themselves to a program, could select whatever services they needed. We had about 30 of these centers around the country, and they appeared to be succeeding. Even the Government Accounting Office, which is notoriously hard to please, was impressed. They called the program the way of the future. Unfortunately, when I left Washington those who inherited my responsibility just closed the program down. We may try it again in my lifetime.

So in the early 1970s we were constantly trying new things that looked interesting and people saw us as worthwhile. I guess I tipped the scales when I decided to put to rest my years of worry over the Westinghouse Report. I never had a lot of confidence in that report, especially considering the methodological problems that Donald Campbell and Joan Bissell and others had pointed out, and I never thought it should be the ultimate assessment of Head Start. So I asked a friend of Head Start, and a very fine scientist and a great synthesizer of data, to take another look at it. This was Urie Bronfenbrenner, who completed his report in 1974. In it he generated the "fade-out" hypothesis — that there is a moderate benefit for a couple of years and then it vanishes. He was just beginning to flirt with his ecological approach at that time and he was thinking about Home Start as a more promising intervention. It's very interesting how data are read and handled by the world, because at the same time I commissioned another report by a Cornell Student, Sally Ryan. Sally looked at exactly the same body of data that Urie had looked at but she came out with the quite different conclusion that there were long-term effects. I have yet to hear anybody quote Sally's piece, but Urie, given his eminence, was quoted everywhere. In many ways, the 1974 statement was much more damning for Head Start than was the Westinghouse Report simply because of the person who wrote it.

Now between 1975 and 1978, Head Start was essentially in a holding pattern marked by uncertainty, confusion and misinformation. For example, during this period the Associated Press and *The New York Times* both reported that Head Start had ceased to exist. After I left government, I went home to New Haven and took refuge back at Yale. Soon I suffered a very serious illness and was not a player for a while. My coming out party was about 1975 when I delivered a keynote address to the National Association for the Education of Young Children. I told them that people should stop saying Head Start doesn't work, because I had some of my own data in New Haven which indicated to me that it did have long-term effects. I suggested that we look at the research specifically for long-term effects, or lack of them, because I didn't see it as a closed issue. In that speech I put into place what has since been called the Cornell Consortium. At the time we had about 10 or 12 longitudinal studies in place of not just Head Start, but early intervention projects of various kinds, and we put all that data together to see what the long-term results were: The Cornell Consortium report revealed that there were indeed long-lasting effects of Head Start. The researchers, at least for the Weikart Project, also did cost/benefit analyses indicating that Head Start saved more money than the program cost.

Unsurprisingly, at this point in time Head Start went from being an abject failure to being a wonderful success. Congress soon gave Head Start its first budget increase since 1965, and advocates such as myself were able to keep the program out of a newly formed Department of Education. This was followed in 1980 by President Reagan including Head Start in his Safety Net Program. What I would like you to note is that the basic Head Start program didn't change dramatically during this 16 year period. All that changed were media reports and perceptions.

Throughout this period of ups and downs there were two sources of constant support for Head Start. First and foremost were the Head Start parents. They never did understand what the research argument was all about. They saw their children learning, eating, and being happy, so they did not share our scientific dismay. In fact, we discovered that about 95% of the parents felt this was a valuable and successful program. This degree of endorsement by users is unmatched by any other large scale social action program. Their support has been very valuable to the life of Head Start.

We were also fortunate that every high-level decision maker who had contact with Head Start, no matter what his or her political lineage, became an advocate for it. It's very hard to visit a Head Start Center without liking it. This included my old superior, Elliot Richardson. When we thought we were going to lose the program, he carried the battle to the White House. Other decision makers who became involved with Head Start were Patricia Harris, who was secretary of HHS under the Carter administration. A name that will probably surprise you, as one never thinks of him as a terribly outspoken advocate of Head Start, is Caspar Weinberger. He developed a close knowledge of the Head Start program during his 10 years as Secretary of HEW, and I was a special consultant to him during that period. Even before

President Reagan's inauguration, I still remember Caspar Weinberger appearing on Meet the Press and praising Head Start, promising that this is the kind of program our new administration will want to support. I can make the list longer. The point is that people with varying political ideologies who deal with Head Start and are responsible for it, really become impressed with it.

I won't spend very much time on what most of you know already about the long-term effects of Head Start. The briefest version of the Cornell Consortium's report appeared in *Science* and is only five or six pages. If one wants the whole story, there's a book called *As the Twig is Bent* which gives you the data for each of the projects. The Cornell Consortium found improvement on reading and math achievement scores, being in the correct grade for age, and being in a regular class rather than in a special class. There were no permanent changes in IQ, but I never thought there would be. There is much more to human behavior than scores on IQ tests, as I've written in many, many places.

Since the first Cornell Consortium there's been a second wave of longitudinal data. At least two studies have followed intervention graduates beyond high school. One by Weikart in the Changed Lives monograph and a second by Martin and Cynthia Deutch. Both of these projects were in the Cornell Consortium. The reports show more college going, less welfare dependency, less criminality, and less delinquency. So there continues to be an impact. My own feeling is that the magnitude of the long-term effects of Head Start really depends upon two factors: How involved parents become in the optimum socialization and education of their own children, and the extent to which schools follow the program with further intervention efforts.

While we've learned a great deal over the past 22 years, we are also now aware of some of the errors we made. One error was searching for some magic period during which fairly minimal intervention would have major effects in changing the course of the child's development. Across the years we have had champions for particular ages as the optimal times for intervention. Some tell us it's the first nine months in utero. Others view the first year of life as a particularly sensitive period due to the development of bonding between the child and parent. Burton White sees the first three years of life as the most crucial. The founders of Head Start nominated the year or two before formal schooling. Beireiter, after being a champion of early preschool intervention, later believed that we should concentrate our efforts during the first three years of formal schooling. Nicholas Hobbs (toward the end of his life) basing his thinking on the works of Feuerstein in particular decided that adolescence is the best time to impact the developing child. Today we are hearing a lot about the first five years of life. It's like all the kids have vanished at the age of six so we don't have worry about them anymore.

I think that all of these views are both right and wrong. The fact is that there is no single magic period in the process of development for the simple reason that each and every period is a magical and important one. Inherent in the view that any one period is especially sensitive relative to others is a concept of development that allows for discontinuity. This discontinuity position has had some value when applied to stages or qualitative differences in cognitive functioning. We should not, however, be mislead by such valuable analytic efforts into thinking that development in its totality is discontinuous. Life is, in fact, continuous from conception through old age. Each period of development grows out of each proceeding period. I am convinced that for each period of development there are environmental nutrients which stimulate further development and/or buffer the child against stress and adverse events experienced during that period. The Head Start program provides just such environmental nutrients at the preschool stage. The fact is that it's really hard to change a child and if you're going to succeed, the only way is to have programs which dovetail. A program for a one-year-old must be followed by one for a two-year-old, and so on, and these programs must interface with each other. One of the programs I started in Head Start was called Project Developmental Continuity. In this, one thing we tried to do was make a child's Head Start records available in the 1st grade so teachers could build upon the child's experiences. So I have long been a spokesman for such a view, although it's not terribly popular yet.

Now the research issues of the next decade will not be whether Head Start is effective. I think that we have finally developed a total consensus in the United States that early intervention has value and has long-term effects. That fight is over. Now we should turn to two questions. One is which children benefit maximally from which type of program . . . . That's why the question, "how does day care affect a child," is nonsensical. The right question is how do different types of day care affect different types of children. The same is true of any kind of intervention program. This is the more differentiated question we should move on to. And then we have what is, to me, still the very toughest question on early intervention, in Head Start or anything else. That is, "What particular processes mediate the documented long-term effects?" What we have now is an early intervention program, and we look at the children as they grow up and see that it made a difference, but why?

I can give you three quick hypotheses. The one that I'm particularly partial to is the role of the parent. If you can change the parent so that he or she is a better socializer of the child, that might be the mediating process, because the parent is there day in and day out, year after year. It's a wonderful lever for growth and development if you can utilize it. We do have some research that shows this to be the case. I refer you to a piece in the *American Journal of Orthopsychiatry* by Parker, Piotrkowski, and Peay, and there is other evidence as well.

There is also the Weikart hypothesis, which is a kind of snowball hypothesis. You make the child a little bit better in the preschool period, and s/he goes to 1st grade and the teacher interacts with that child somewhat differently so he or she becomes a little better yet, and then the next grade better yet. I'm troubled that while the Ypsilanti group had been pushing this hypothesis, they refused to test it. There's a simple test, which is to go into a school room and see if Head Start children are indeed responded to differently than others. Actually one of the things we discovered in the early years is that teachers, rather than loving Head Start children and treating them better, tended to have problems with them. There is certainly a discontinuity between Head Start, where there is an emphasis on individual development, and the classroom, where more regimented behavior is expected. The Head Start child has to unlearn a style of behavior that is alien to the classroom, whereas a child who has not been in Head Start is less troublesome to the teacher. Thus, I don't have a lot of confidence in the Weikart hypothesis. But again the work hasn't been done. These to me are not things that Dave and I have to argue about. They're empirical issues. We should simply get on to testing them.

The third hypothesis involves a factor in Head Start that we have not paid nearly enough attention to — health. People forget that Head Start is probably the largest provider of health services to poor children in our nation. The way we do long-term outcome research, if you think about it for a minute, is really the difference between two means. You have your experimental Head Start children, and 15 years later you get a mean on something, then you have your comparison children and you get a mean on that same something and then you compare them. Well, means are very sensitive to what we call outlying scores. If you improved the health of three children who would otherwise have been sick in a group of 30 children, that would almost be enough to give you the kinds of differences we find, which are not immense. Of course, those of us who value children would see the program as successful if the health of only one child improved.

My point is that in spite of all this beating on the drums about how wonderful Head Start children are 20 years later, if you compare them to middle-class people in their early 20s, they still don't measure up. If you look at their own comparison group, of course, they look better. It's not a whopping big difference, although it looks like it may have practical significance. But I think there has been a tendency by the Cornell Consortium Group to oversell the results. How much effect do you really expect to have? You give children a program for a year when they're four and you look at them when they're 20. To me, the fact that you find any effect is remarkable. I don't believe in magic, I never have. That's why I like to unravel the processes.

In the early years of Head Start an error was perpetuated concerning the degree of plasticity exhibited by the human organism. I agree with my colleague, Sandra Scarr, in her depiction of the 1960's as a period characterized by naive environmentalism. Let me describe the atmosphere of the '60s so we can understand why everyone thought we could accomplish so much by doing very little. Two popular books at the time were my friend Joe Hunt's, *Intelligence and Experience*, and Benjamin Bloom's, *Stability and Change in Human Characteristics*. These scholars made it sound like it was very, very easy to change people. This was also the period when White at Harvard and Held at MIT made us all giddy with their reports of just how much improvement in cognitive functioning could be achieved simply by placing a mobile over an infant's crib. I could still remember one day when I was on the lecture circuit, I gave some boring, dull talk about something or other and afterward people came up to ask questions. One lady, about 45 or 50 I guess, was kind of hanging back and finally she drew up her courage and walked up and said, "Professor Zigler, I've waited to ask you a question because it's very important to me. You know, when I was a young mother we didn't know about mobiles and I didn't put one over my child's crib. You're such an expert, perhaps you could tell me how much damage did I do? I assumed she must have had a retarded child and was blaming herself as parents often do. I asked more about her child and discovered he was at Cornell, where he made Phi Beta Kappa in his junior year. I asked her how much smarter she thought he would have been if she had put a mobile over his crib? She said she'd never thought about it, but she guessed he was doing just fine. I told her not to worry about it. You can see the anxiety these reports generated.

This fierce environmentalism carried along in banner headlines by journalists and popular writers at the time. There was a piece by Maya Pines in the Sunday *New York Times Magazine* in which she informed us that a pressure cooker approach to early childhood was the solution to the poor school performance of economically disadvantaged children. The Deutchs' Program in New York City, the Harlem Project, also got a lot of attention. This was the same one where they have just done a follow-up on the graduates. The Deutchs found a 10-point IQ increase in children over the course of their 10-month intervention. The one common finding, no matter what you do, is a 10-point increase in IQ, which I really think is a difference in motivation and has very little to do with formal cognition. But be that as it may, they got their typical 10-point increase. The journalists in New York City did a little simple arithmetic — 10-month program, 10-point IQ increase — and came up with a striking headline for the New York paper: "Program Increases the IQ One Point a Month." I had a little two-year-old at the time and I was very tempted to send him down for about 40 months worth.

The planners of Head Start were not immune to such naive and grandiose expectations. We were going to take children out of the slums of this country, the Harlems, the Appalachias, and were going to put them into a program for six or eight weeks and then they were going to be forever wonderful. Remember that the original Head Start program was a brief intervention during the summer preceding the child's entry into school. I'm afraid many actually thought that a six-week program would be a panacea for all of the problems exhibited by economically disadvantaged children. It was an inoculation model. We insisted on ignoring the biological integrity of the person and treated the human being as an organism who was highly malleable and probably perfectable. We should have known better.

I tried to slow things down a little, but that was hard to do because it was a time of great optimism. We were going to wipe out poverty in this country and we were going to do it with four-year-old children. The evaluations of the six-week program didn't help, since they showed the standard IQ increases of 10 points. This only fostered our belief in the almost unlimited potential of environmental intervention.

Thankfully, we came by some wisdom early in the development of our nation's Head Start program. We soon realized that children cannot be inoculated against the ravages of poverty experienced year after year over the long course of development. After the first summer, Head Start became a more realistic one- and in some places a two-year program. Many were aware that even a year or two was not sufficient to meaningfully impact a growing child. Thus, was born our nation's Follow Through Program, which extended the intervention through the first three grades of elementary school.

Some of the views of an endlessly plastic organism remain with us today. My friend, Joe Hunt, hasn't changed one bit. He continues to argue that the reaction range for intelligence is 100 points. For the behavior geneticists,a reaction range is simply "What is the difference in intelligence between the worst environment and the best environment." People like Cronbach and Ed Zigler look at the same kind of data as Hunt and conclude the reaction range is about 25 points, which is still quite a bit. However, there can be little doubt that reaction has set in in opposition to extreme environmentalism.

I'm an historian of the nature-nurture controversy and see it to be like a pendulum. We push environmentalism for a while and we go too far, then we push the genetic approach and eventually push that too far. We never seem to be able to get back to the center of things. One strain of the reaction can be seen in the views of Arthur Jensen and his porters. Another can be found in the work of a major developmental thinker, Jerry Kagan at Harvard, who now espouses a form of neomaturationism, the roots of which can be found in the work of Arnold Gesell. It's really very funny if you're an historian of science, because Joe Hunt said he was reacting to Gesell. Nobody was paying any attention to Gesell by 1960 by the way, so he set up the straw man of maturationism and the fixed IQ which nobody believed anymore. So we went from Gesell to Hunt and now we're back with Jerry Kagan to the starting point, so we've come full circle. I just reviewed a brand new book that champions the genetic point of view by a very good worker in mental retardation, Herman Spitz. The title of the book is, *The Raising of Intelligence: A SelectedHistory of Attempts to Raise Retarded Intelligence.* Spitz takes a very genetic position and his answer is not much. So we're swinging back in that direction. Caution is advised. In the '60s we probably did oversell the importance of early childhood. But the threat today is that the importance of early childhood will be undersold.

Another error we made that always has bothered me is to put all poor children in one set of centers and more wealthy children somewhere else. In fairness to the founders of Head Start, we put into place a principle that 10% of the children could be from nonpoor families. If I had to do it all over again, I would change that to one-third. I think you need at least that ratio to get any of the benefits that intermixing could give children. But that was another one of our mistakes. However, I still think it's fair to take a positive view of the overall history of Head Start.

This positive view does not mean that we should rest on our laurels. I think of Head Start not as a static program but as an evolving concept, an effort that must continue to grow and develop.

In fact, one of my biggest problems today, as this country moves toward universal preschool education or universal day care, is where does Head Start fit? What is Head Start, and what is its place in the mosaic of programs for children?

I can tell you one thing that Head Start or no early intervention should ever be. I think we must repudiate forever the view that higher IQ scores and their close correlate, elementary school grades, are the ultimate goals of early intervention efforts. I'm very much afraid that the new excellence movement in education, the accompanying back to basics approach, and the new accountability we're hearing about which leads to the testing and retesting of very young children, represent a new threat to what is best about Head Start. The question is whether we shall commit ourselves to a narrow, cognitive development approach or to a wider, whole child approach. So far as Head Start children are concerned, the back to basics and cognitive development emphasis are based on fallacy; namely, the now discredited deficit model which held that the central problem of economically disadvantaged children is their inherent intellectual inadequacy. A respectable body of empirical work has now made it abundantly clear that poor children have much more intelligence than is typically attributed to them. What we should be working on is not increasing IQ scores but rather the production of socially competent human beings who use all the intelligence they possess.

I have long argued that the goal of our intervention efforts for children should really be social competence. I tried to define this, if you want to read it in a piece I did with Penny Trickett for the *American Psychologist*, called "IQ, Social Competence, and Evaluation of Early Childhood Intervention Programs" (1978). I think that social competence will eventually be defined by several factors, not the least of which is physical and mental health and well being. I don't think we pay enough attention to the role of physical health and nutrition in the functioning of children. No whiz bang pedagogy is going to help a child who is so hungry that he or she falls asleep at the desk. So I continue to push physical and mental health as a measure of competence. Of course, I do believe we should do all we can with formal cognitive ability, including language and other school related intellectual skills. And I think there's quite a bit that can be done there. Even if you believe that the heritability index for intelligence is greater than .5, which means about half of intelligence is genetic and about half is environmental, there's still a lot of room to work in that area. But it is just as important and easier to get benefits from trying to improve emotional/motivational factors. For example, we should work on children's locus of control, because so many poor children don't think what they do can make a difference (their parents think that as well). A healthy and appropriate responsivity to adults, and development of a positive self-image are the kinds of factor that are more easily changed than intelligence.

We must also do more to work with parents. There have been some very important changes in the field of child development over the years. In fact, I can hardly recognize this field from the time I came into it as a graduate student 30 years ago. We had then the concept of the dyad. There was the mother and the baby, and all of the experiences were unidirectional from mother to child. Bell's notion that there was an interaction, that the baby influenced the parent, is only about 20 years old. The father was nonexistent until about 20 years ago. Today there's a whole different view, and your meeting here expresses it in a way. This change owes much to Urie's ecological model and also to the transactional model of Arnold Sameroff. We now see the child as sitting in this complex dynamic system called the family. That family, as complex as it is, sits at the intersect of all of the other social institutions. For example, if there's vast unemployment, it impacts the child, but no family determines economic conditions so you have to look at the entire world of work. The media, the school, and all other institutions are also impinging on the child, usually through the family. So it's quite a complicated systems approach that we're now using in understanding human development. Our theories are converging on the notion that the unit of intervention is the entire family. Family support programs were unheard of not too long ago. Today there is the Ounce of Prevention Fund and a huge variety of family support programs that I came in contact with when the Bush Center hosted a national conference on family support in America. This resulted in a book, *Americas' Family Support Programs* (1987). The fact that there was enough material for a book shows that this is the direction the country is taking.

Well, I think I've probably gone as far as I can on the Head Start program. What I thought I'd do for a group of this kind is to very quickly run through some bills that are now before Congress. You not only have to get ready for them, but you should be impacting their forms now while they are being written or amended.

We have before Congress today the Infant Care Leave Bill which will provide something like 18 weeks of unpaid leave for the mother or father. Given the Swedish evidence, it's clear that probably 90% or more of that leave will be taken by women. I've been particularly interested in this bill because not long ago I headed a blue ribbon commission at the Bush Center at Yale. We looked at the issue and conducted many surveys and analyses, including what did European systems look like. Our studies have just come out in a book, *The Parental Leave Crisis: Toward a National Policy*, edited by myself and Meryl Frank. The commission was set up and funded, interestingly enough, by the Reagan people. It included Jerry Kagan, Berry Brazelton, Urie Bronfenbrenner, Betty Caldwell, Julie Richmond, Sally Provence, and other prominent specialists. That was the last joint effort by Wilbur Cohen, who died shortly after the work of the commission was over.

We and our staff looked at this problem for two or three years, and we came out with a recommendation for this country which was about the median of what the world does for families. This is a six-month leave with three months being paid at about 75% of salary. The cost wasn't tremendous. Our suggestions were picked up by the Congress and are now making their way through the legislative process. Of course business was fighting this bill, saying it would cost $16 billion dollars. Then the GEO studied it and came up with the number of $500 million, which is primarily the cost of the medical insurance that is held in place which is a very important feature of the bill.

By the way, if you would like to look into the soul of some cross between an advocate and a behavioral scientist, I was confronted with a real problem when I was asked to testify in favor of this bill. It really is an absolute nothing bill, far from anything that one would call a good infant care leave policy for a family. If you don't have any money, how in the world could you take that time off? Well, even Yale professors know that something is better than nothing. I swallowed hard and became an advocate for the bill because I am already thinking about the next bill. Turning to history again, look at the first Social Security law in this country. It was pathetic — a guaranteed recipe for poverty for old people. But what happens is you get a principle into place then you build on it. Social Security is still not great, but it's quite defensible. I'm working hard for the parental leave bill not because I think it's a great bill but because I like the principle. If I can get that principle into place, over time we can work on it and make it better. If it fails to pass, there's nothing to make better.

Another bill that I'm developing is a model to solve the child care problem in America. I'll give it to you very quickly. I would like to see two systems in every school building. System #1 would be the formal schooling that we already have. The second would be a child care system, which would enroll children between the ages of three and five. From six to 12, the child is in the regular school program as well as the child care system. It would open two hours before the formal school day and stay open two hours later, providing before- and after-school care and vacation care.

There would be three other features of my child care system. First, there would be the outreach program offered to parents beginning in the third trimester of pregnancy. This is the Parents as First Teachers model that we already have in every school in Missouri today. There are home visitors who are supportive of the family, from prenatal care through the early bonding, usually remaining involved until age three. The second outreach program is very, very important to me because the child care system that worries me the most is the family day care system. It's very heterogeneous. You find everything in it, from the excellent to the awful. In testimony I gave, I said family day care is a cosmic crapshoot. This was picked up by the *New York Times*, which presented an editorial with that title. They described children who had burned to death in family day care homes in New York City. I don't know if you're aware of it, but that little girl who fell in the well in Texas was staying in a family day care home. What I mean by cosmic crapshoot is if you're lucky, you knock on that right woman's door; she's warm and understanding, so it's like you've gotten a new family member. So I'm not damning all family day care. But it can also be terrible. Within my plan I would use the model developed by Elizabeth Prescott and June Sale. All the family day care homes in the neighborhood around the school would be tied into a network. The hub of that network would be the child care part of the school. They would help monitor the system, train the caregivers, and be a general support to those who need it.

The third piece of the school-based child care system would be an information and referral system where parents could go to find other services that they might need. This would include night care and a variety of things that you can now get through good information and referral systems throughout the country. That's the system.

There are only two further details that I'll mention. One is who's in charge of it, and two, how do we pay for it. Within my plan I say that child care, like education, is not mentioned in the Constitution. Therefore, I feel that child care will be a state responsibility just like education. At the operational level, I am pretty much convinced that the child care system should not be in the hands of formal educators for three reasons. One is that principals and teachers are already so harried and so pressured to upgrade scores that the last thing they need or want is another responsibility. Another reason is that you really want to start at birth, as I want to, and continue the care and training of very young children. The formal school system does not have the expertise to take on that part of the child. The third reason is simply cost. If you cost out what it would take to provide the system at the level we're now paying educators, no nation could afford it. They're way too expensive. This doesn't mean that I'm willing to sacrific quality. Essential to my plan is a minimal quality standard for every one of these school child care systems. I see that system being run by a BA or MA level, early childhood educator. For the three- to five-year-olds, there might be a master teacher with a BA. For caregivers, I would use Child Development Associates as much as possible in order to be cost effective. Another bill I'm working on is an attempt to develop in this country what other countries have developed — vocational courses so that a young woman can become a CDA in high school. There would be a good four-year vocational course and an apprenticeship with more on-the-job training. She could earn an advanced CDA.

Who pays for the system? While everyone agrees that we really need child care, we have not wanted to deal with its cost. I've tried to cost out the price of good quality — not optimal quality, but good quality — care for all children of all ages in the United States. The best estimate that I can come up with is somewhere between $75 and $10 billion dollars a year. The cost is absolutely immense. But the demographics are such that 75% of mothers with school-aged children are working today, 55% of mothers with preschoolers, and half of mothers with babies under one year of age. Our best extrapolation is that early in the next century, we're going to have 80% of all women in the out-of-home work force. At that point in time, I think general taxes will pay for the child care system. In this interim period, given the very high cost and the fact that neither Washington nor the States have the money, I'm proposing a fee system adjusted to income, so families pay what they can afford. This system was originally written into the 1971 Bill. I would also do all I could to see that employers include child care as a regular fringe benefit to help defray the cost. The federal government should subsidize some of the expense, particularly for handicapped and for very poor children. Because the price is so high, everybody is going to have to pitch in in someway to pay for it. Now, obviously, I'm not talking about nirvana tomorrow.

Step #1 in my plan would be for the federal government to pay for a minimum of 60 demonstration schools, at least one per state. They will also have to provide money to help states clone those schools if they catch on like I think they will. That bill for the demonstration schools involves about $120 million a year for each of three years. It has very wide support. Sen. Dodd will probably introduce it. Sen. Hollings and Sen. Hatch are very enthusiastic, and that's about as broad a political spectrum as anyone can put together.

We may also get a second child care bill before Congress this year. My bill will only put into place a system, and the second bill will put some money into that system. Senator Hatch, believe it or not, has introduced a child care bill which includes several different features such as insurance. Essentially it calls for an expense of $250 million dollars. Well, if my estimate is anywhere near target that's not going to make much of an impact. But again, something is better than nothing and $250 million is $250 million.

There's another bill that a lot of people are betting on. I'm not, although I like the people and I like the bill. I'm just a pragmatist and a realist, and a man who has suffered through two vetos of child care bills that I've worked very hard on. One in 1971 and another in 1976. This bill is called the ABC bill, put together by a coalition of 80 organizations called the Alliance for Better Child Care that is being spearheaded by the Children's Defense Fund. They're asking for $2½ billion dollars the first year, going up to $4 billion in about three or four years. These are all my friends and I wish them well. But given the problem we're having in Washington with our national deficit, to say that the solution to child care in America is for the federal government to come up with 4 billion dollars a year is just not realistic in my opinion. Secondly, if it were passed, there's little doubt in my mind that it would be vetoed by President Reagan. So the game that we're playing in Washington now is somewhere between $250 million and $2.5 billion. The object is to find that threshold where Reagan will sign the bill.

Now, I'll give you just one more bill and then I'll quit. There is a prevention bill which I'm working on very closely with Barbara Mikulski and Sen. Dodd. We have two prevention movements in America, and if we could find some way to combine those two, we would finally have a unified prevention movement. The first piece of the bill concerns the grassroots family support groups. There are several thousand of them, and they're starving. What I'd like to do is get a kitty of money to allow those places to start up and to stay in business. They are a very cost effective mechanism. Heather would agree, and she is one of our nation's great authorities on this.

The other piece concerns the prevention efforts that go on in the universities — the work to develop models, to implement them, to test them. These include the Olds model in Elmira, the home visitor model, and Craig Ramey's project. If you want to see others, Richard Price at the University of Michigan chaired a committee of the American Psychological Association which looked at all of America and picked out the best prevention programs. Both university-based prevention people and the grassroots people have strengths that the others don't have. I'm working on a prevention bill with several senators to help the university people implement some of their models at a grassroots level. Senator Hatch is interested because this kind of grassroots effort is in the best tradition of our country. The notion of people helping each other is not only cost effective, but it appeals to the left and it appeals to the right. It's not going to be a huge cost bill. I think we're talking somewhere between $75 and $100 million dollars. To taxpayers like us that may sound like a lot, but it really isn't. At the Pentagon, that's a rounding error.

There's a lot of support for this type of effort, so keep your eye on it. Of course it won't be for a while yet. At the Bush Center we're still trying to put the pieces together. I'm working very closely with Bernice Weissbourd at the Family Resource Coalition on the grassroots piece, because her organization tracks the grassroots groups and is a support system for them. For the university-based part, I'm working with several people including Rick Price and David Olds. Once I put together a coalition of people to help me write this bill, we will work to get it drafted down in Washington.

Well, that's what's going on. I've talked a little bit longer than I wanted, so why don't I just throw it over for questions.

(*Chamberlin*) Could you tell us what the parent's role is in your school plan?

(*Zigler*) There's a book I did with Ed Gordon called *Day Care: Scientific and Social Policy Issues*. There's a chapter in it in which I point out that I'm appalled at the lack of real partnerships between parents and childcare givers in America. I strongly believe, as you must have picked up from my talk about Head Start, that we have got to weave those two together. It has to do with principles of development which show the need for continuity in children's lives. What I'm seeing in child care today is really very frightening. I have heard child care workers say this would be a wonderful child if they didn't have to send him or her home, and I've heard parents say this would be a wonderful child if they didn't have to send him or her to day care. We have not done the job we should be doing to educate parents about child care. We need a tremendous parent-education campaign. Too many parents think that when they buy child care, they're buying a service that allows them to go to work. We have to transmit that they are buying an environment which determines in considerable part the growth and development of their children. If that growth and development are going to be optimal, we have to assure the closest partnership between the caregivers and the parents.

Myself and Polly Turner at the Bush Center have a piece coming out in which we've reviewed all of the literature on why these partnerships are so important. You know, we don't use our knowledge base enough. The literature is unequivocal. Wherever you have those partnerships, children profit. Where you have discontinuity and adversarial relationships, children are hurt. Head Start is the most obvious example but every bit of research is totally consistent. So, knowing that literature and working with it, we are attempting to develop models. The way the child care law will probably be written is that every state will have to come up with a plan for their school or schools. They will have a list of certain things they must include. One will be to have standards. Another will be to promote good parent-caregiver interactions, and they will have to be specific about how they are going to do this. This will be part of the legislation I'm sure.

(*Bauer*) As you've been speaking, I'm struck that you're used to dealing with people who make decisions and pass laws and spend money. One of the things we've been kicking back and forth here in the last days has been how does one effectively speak to the people who are making laws and what logic or arguments or persuasion could one use that they listen to? I would think that you probably are in as good a position as anyone to give us clues as to what sorts of arguments one uses to make the case that we all wish to make at either the local, state, or federal level.

(*Zigler*) I can only tell you what I've learned, and it's very personal. The first thing that I do is try to figure out the ideology of the person with whom I'm talking. Now the fact of the matter is that for many years I've been selling exactly the same thing. But when I talk to Sen. Hatch I talk in terms of human capital and the employability of people and national defense, suggesting that we must treat children well if they are to become competent adults capable of running the country. When I talk to someone on the left of the political spectrum, I talk about what's right for kids and what this great country owes to its dependent citizens, be they children or the aged. My advice is to push all the buttons you can push. For the child care bill, I make very clear that the goal is the optimal development of children. Nobody is against that. Everybody is for the optimal development of children. When dealing with conservatives, a wonderful resource for us is the brand new report by the Council on Economic Development. There are two key words in Washington today. One is competitiveness, meaning our concern with how we are going to stay up with the Japanese and the West Germans. The other is human capital, which includes children. We have to see that every child develops as optimally as possible, so he or she will be a good employee and help us be competitive. That's at the level of industry and business. At the level of a human being, I think in terms of self-actualization. I like to see children become all that they can be — that's enough of a goal for me. So try to appeal to as many different points of view as you possibly can. Don't just make one argument, make six, and somebody will pick up one and somebody will pick up another one. You're selling exactly the same thing, and you're not being dishonest. You're trying to show the many bits of profit in a program, and the more the better.

(*Weil*) I think Head Start is an example of that and in this report that I did about Maine's expansion of Head Start I quoted an article by a man named Scary, I believe, who writes from a conservative perspective. The article is called 'The Charmed Life of Head Start' and he talks about how Head Start has been a program that has not been perceived as only a low-income program for poor people but as a good program for little kids. He talks a lot in the article about its appeal to the right wing because of parent involvement, because of local control, and its being in community settings that people can readily see and identify with. Those are the same features that make it as appealing to the left as well as to the right. I think that could be very true of the plan that you're proposing for this child care system. There are things there that could appeal to a very broad array of people, using the intact school system that's there, using buildings that exist, and using various parts of the infrastructure.

(*Zigler*) I think that's true. In fact, at the last governor's conference I tracked this idea and made the point that we have in this country an investment of one trillion dollars in our school buildings. We're not using those buildings optimally. Of course some are being overused, and we may have to use prefabs to house child care in certain places. But I couldn't agree with you more.

(*Bauer*) What were the governors' reaction. Are they waiting?

(*Zigler*) They're not waiting. The news on this front is surprisingly good. By the way, don't take the bill literally because I'm changing the thing all the time. The big problem is money. I thought I'd tap property taxes but I'm already caving in on that. A big reason is that senior citizens, who are a very potent lobby, don't want more property taxes, and they don't use child care. I'm probably going to call together a think group including economists to figure out how to finance it. If any of you has a brilliant idea on how we're going to fund a hundred billion dollars to pay for child care, please share it with me.

(*Pierson*) I don't have a brilliant idea but I'm concerned that if we exclude schools on the basis that the cost is too much, we will create an underclass of child care workers. I think we underestimate the ability and the importance of older peers as a resource, as an inexpensive resource, in a way that could help transform what the nature of schooling is about; by having some cross age work, by having, and I know Urie's talked about this, a community service requirement, but building in ways in which teenage and younger adolescents have some role for younger kids.

(*Zigler*) I think that's a terrific idea. Again, let's talk strategy for a minute. I think one of the appeals of this proposal is that it's so simple people can immediately understand it. For example, I now have a commitment from Connecticut to build three of these schools without any federal money, I have a commitment from Colorado to build three schools, and I have a commitment from Missouri to build at least one. They're not waiting, they see it. When I first announced this, I soon heard from my friends at the American Academy of Pediatrics. They said that if the system was starting with the home visitor model, it would be a good point to introduce inoculations and other health initiatives that would be so good for children and families. The Academy as usual is dead right. I think you're right and I think they're right, but I'm not going to do what they or what you just suggested. If you have a circumscribed program to sell, people can see it and will run with it. If you start adding this piece and that piece, before long it gets very involuted and difficult and complicated. We must think in terms of evolution. You get the model, you get the system into place, and then you begin adding to it. Eventually we could integrate cross-age interactions, health components, etc. But first let's get the system into place and figure out how to pay for it. Then once it's there at the local level, people such as yourselves can work on how to expand it.

My hope is this will be like Head Start. Head Start has no set curriculum. Actually there is no Head Start. There are two thousand Head Start centers. In any one state you can find a center that looks like Montesorri and another that looks the opposite. Another may be doing some combination of Home Start and Head Start. They're all different. But that's part of its strength. This is a pluralistic society. What we did was draw a rough model of Head Start, with a few demands such as provision of health services and parent involvement. If you meet those demands we'll give you the money, and then you can build the thing locally in a way that makes the most sense to you. That's how I would like to proceed with the child care plan. The lessons I learned in over two decades of Head Start are helping me again.

(*Albano*) A way to raise your money is to do what New Hampshire does and that's a sin tax as we call it — a tax on beer, liquor and cigarettes. If you add a surcharge to that, you're helping to do two things: cut down on consumption of health hazards and fund your program.

(*Zigler*) That's not a bad idea. My only question to you is whether there is enough money. Are there enough big bucks emanating from those types of purchases?

(*Albano*) Obviously, I haven't had a chance to cost it out, but I would imagine that you'd be able to get a good portion of it and then maybe have some way to match that. In other words, the Federal government, to get to your magic number of between $250 million and two and a half billion dollars.

(*Zigler*) What's worrying me is the real number. Maybe the sin tax could provide the 2.5 billion. However, we're talking about providing every child from age birth to 12 with, not the best care we can think of, but the kind of care that's dictated let's say by the 80s standards. This could cost 75 to 100 billion dollars a year. I just don't know if there's that kind of money there. I will cost it out and see what I can do with it.

(*Albano*) Maybe it's a graduated type of thing where it's introduced into the states that are willing to do it first and then using those states as a model and adding on to that.

(*Zigler*) That's a good idea too. I'm an old Donald Campbell fan. I believe in an experimenting society. When we put this money out there, states are going to do different things with it. Somebody has to pay for the services provided in the system, and the states are going to find different mechanisms. It will be very interesting to see what various places come up with, and what works best. What we will need then are more process evaluations. We will need to see what gets in the way of good services, what makes the system work better, what models look the best. So, that's the kind of research we'll probably do within that system.

(*Albano*) The other part to that is that the most popular issue today is how do we eliminate or reduce the possibility of AIDS in our society. I don't know if there's any legislation that could be merged with AIDS in the sense of promoting an educational component dealing with our very young. I don't understand totally your model yet, but if you're talking about the school, and school education and parent education, you are talking about AIDS related information and perhaps there's some way to generate additional dollars by attaching it on to that.

(*Zigler*) That, again, is not a bad idea, and it fits with what I said about trying to find as many assets as you can to win a broad base of support. However, let me give you a bit of a warning. I have real battle scars and they've made me leery if not paranoid. You see how quickly I came away from the property tax once it became apparent that old people would probably fight me, and they're a very effective lobby. There are other lobbies out there. Heather was with me when I laid this out in Missouri a week or so ago. A few women there made me feel like I was going through a time warp. Remember, Nixon vetoed the 1971 bill after it passed both houses of Congress because of strong right-wing opposition. Those people are still there — Phyllis Schlafly, Falwell, Robertson. They're hollering that what we want is to make women go to work, and then their children will be raised in school buildings rather than in homes. That's why I see the fee system as so important. It isn't just to get money, but it's to emphasize that the service is voluntary. If you don't have any need for the system, you certainly don't have to use it. No three-year-old should be in school all day if the parent is not working. I bring this up simply because AIDS is one of the those kinds of issues too. I would be very, very cautious about it. Everybody's against sin so a sin tax probably won't cause much trouble. But the AIDS thing might, so I'll have to think on that one.

(*Wallner*) I would like to know what the public education community is saying to you about this bill? How are they receiving it?

(*Zigler*) I was pleasantly surprised. I haven't talked to all the players yet, as this plan has gotten going faster than I really expected. I feared that the school systems would want it for themselves. I've sat with two systems now and they don't. They do seem to reflect what I was saying. They mentioned a survey in which teachers were asked what problems they thought were preventing children from learning. Fifty-one percent pointed to the latchkey problem. So they want something done about latchkey but they don't want to do it themselves. Maybe that's why they're so receptive to the idea of having child care be a separate system within the schools. Of course, the educational establishment is a big and complicated one. There are key people whom I haven't talked to yet. One, if we can ever get our calendars to mesh, is Bill Bennett. If this money goes through the Dept. of Education, where's Bennett going to be on this? I don't know yet. We're going 'to talk.

Others I'm trying to put on my agenda are the teachers' unions. Unions must do what unions are supposed to do. If there are jobs, they may want those jobs. They may not want to see those jobs go to somebody in child care if those jobs can be held by teachers. My hunch is that if they're far thinking, they would hope to unionize that second system. That would be fine, because child care workers don't make enough.

One of the saddest parts of this whole story I haven't gone into yet. We must do something in this country to upgrade the pay, the training, and the status of people who take care of children. Today in the United States, 75% of all child caregivers make less than the minimum wage. For family day care mothers, that number is 90%. The average pay for a child care worker is about what we pay a zoo keeper — $12/$13,000 a year. Yet whenever we talk about the importance of quality care, the heart of that issue is the qualifications of the caregiver. So it's in our interest to upgrade that system. The fact is it's very hard to attract school teachers now because we're not paying enough, so how on earth are we going to get good child care workers? These are very massive problems that we haven't begun to tackle them yet.

(*Albano*) But how do you get men to be in child care work because we talked about community approach but we still keep eliminating in whatever approach we're taking, we're eliminating men.

(*Zigler*) I wish we could attract more men. There are a few in the elementary school system. The fact of the matter is that in 25 years, I have yet to meet one family day care father. Has anybody?

(*Mitchell*) Yes. We have a county-wide system and we have two men out of 40.

(*Zigler*) So there are a few then. That's good news. I think men can be good caretakers, and it would make Mike Lamb and all his people very happy to hear me say so. There's another good reason to have men in the system. Whenever jobs are totally female jobs, they don't pay very much. Unfortunately, given what child care workers earn today, I don't know if many men would be interested. Looking at it from a social historian's perspective, I don't know whether it's possible to change our view of child care as women's work. For example, now we're hearing so much about marriage contracts and how men are going to roll up their sleeves and take care of their babies and do half the housework and so forth. Most surveys indicate that about 7% of that work is actually being done by men. That doesn't really surprise me knowing how slow social evolution is. It has taken a long time for social gender stereotypes to develop. The idea that we were going to change them in 10 or 20 years was unrealistic. If we keep working at it, we might succeed in 50 to 100 years minimum.

(*Weil*) I like the idea that Don had about about interage grouping. I have worked with some teenage boys that have worked really well with young children and that may be a beginning step for getting some men into that field.

(*Zigler*) That's a good idea. I tried something like this. In the early '70s we started the Education for Parenthood program in about 3,000 schools. I insisted it include boys and that both the boys and girls had to actually work with small children. Our experience in Head Start, by the way, was that young children adore adolescent boys. We should develop more and more mechanisms to get boys in particular in contact with younger children, so I couldn't agree with you more.

(*Little*) Last night's conversation after dinner focused a lot on the frustration of not being able to come up with what I call a zinger for the concept of parenting and how much of the discussion on the review of Head Start, and the subsequent aspects again came up with parenting and yet we're not able to communicate clearly. I'm not even sure we know what parenting is well enough to be able to structure it in a fashion to get it into the proper perspective with regard to many of these initiatives that we undertake. I'm saying that as an individual with relative inexperience with many of the issues that are being addressed here but again and again we come up with the judgment that parenting is valuable, it's in your data, and it's implied in the discussion of the initiatives. And yet, last night after dinner, we sat here and tried to come up with the way to market the concept of parenting and nobody could do that.

(*Bauer*) Manoff said don't even try.

(*Little*) Don't even try — that was the conclusion last night. It's an intangible, you can't sell it because we don't have the conceptual framework in social marketing to deal with what parenting is and, yet, to play the devil's advocate, many of these congressional and other initiatives that you talk about really are dependent upon recognition of parenting.

(*Zigler*) Well, I'm not convinced that parenting is all that complicated. In fact, I chaired a national conference on child abuse which led to a book called *Child Abuse: An Agenda for Action.* At the conference nearly 400 specialists came from all over the country. One of their conclusions was that giving parenting education to teens is too late. Our new demographics are very dramatic. The fact is that 25% of kids now are an only child. It's quite possible for one of these children to never see a baby until he or she takes one home from the hospital. What the conferees suggested was to start teaching parenting in the first grade, and at progressive ages go into different aspects of it. Betty Caldwell developed a course on parenting for third graders and somebody named Kent has one for fifth graders. The Education and Development Corp. came up with a parenting course for teenagers. You know, in America we put such a course into 3,000 schools. In New

Zealand, it is now in every school. They saw more hope in it than we did. I would like to see us work on a parenting course which begins with younger children and goes with them through high school.

Parenting really is very important. Part of it is just knowledge. Take the phenomenon of child abuse for example. It's very sad that there are people who actually believe that when a six-month-old baby defecates in the diaper, they're doing it to be mean and you should hit the kid. If we didn't teach anything but the Gesell norms, showing the normal course of growth and development, future parents would be ahead of the game. The kids really like these courses. So much about parenting is interesting and never dull, especially if you have a lab where students actually work with kids and can bring those experiences back to the classroom. So, I'm going to continue to work on education for parenting.

(*Little*) But you know most of the pediatric residents that we educate have yet to assume responsibility for a child at any time in their life in terms of the physical and emotional well-being of a child. I would dare say that most of the teachers, child psychologists, and other people that are educators in this country, the way things are right now, have yet to have practical confrontation with the day-to-day parenting skills, the tangible and intangibles, subjective and objective aspects of that including the tensions and pressures that might lead to physical or emotional abuse. We've got to deal with that issue.

(*Zigler*) But why can't we build this into the experience.

(*Little*) I would hope so. That's what I liked about some of the things you said.

(*Weil*) The speaker last night was talking on social marketing and selling community wide, very simple ideas, and I thought to myself at one point during your delivery, you've already learned about social marketing because you were talking about keeping an idea simple and selling it. I think the Missouri program talks about 'Parents as Teachers' and, you know, it may be that when we talk about parenting or parent education and Manoff was having a hard time understanding what we meant by that, that a phrase like "Parents as Teachers" is something that's much more readily grasped in a mass media kind of way. The word parenting just doesn't convey that. It may be that we need that kind of term like 'Head Start' which is simple and easy to grasp and comes to mean a whole lot of things to a whole lot of different people.

(*Zigler*) We should certainly work on that.

(*Weiss*) I was curious in terms of the integration of some of the family pieces. I know, you talked in your presentation about the tensions between child care people and families and I think there's a lot of literature that suggests that there's tension between schools and families. I wondered, as you fine tune your piece on the school bill that you're talking about, if you've thought about strategies to try to get institutions, whether it's day care people or school people, responsive to parents in the way that I think you want them to be.

(*Zigler*) It's very tough to do. You know, we have one organization devoted to this based in Boston. Lynn Kagan is a big player.

(*Weiss*) He used to do the Institute for Responsive Education.

(*Zigler*) And also used to be in the Dept. of Education. Schools really don't have a very good track record when it comes to parents. When I was in Washington I developed the regulation that gave parents the power they have in Head Start, which I think was the right thing to do. The minute I did that, I heard from schools all over the country. Many said they couldn't have Head Start in their schools any more because I gave parents more power than they could possibly permit. So I don't know what the answer is, but I do know it's a very important problem. I'm developing some models myself of how parents and child caretakers ought to interact with one another by examining good practices that we already have. It's not that some people aren't doing this: some are doing it just fine, but others are not doing it at all. So, we'll just have to work much harder on that one.

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A School System Based Approach to Promoting Healthy Families and Children

Presentation by Donald Pierson, Ph.D.

(*Chamberlin*) After that view of the national scene we'll come back to the state and local level and see what's been going on in school systems in Massachusetts and around the country. I'm delighted to have Donald Pierson, PhD, who is now Professor of Education and Director for Field Service Studies at the Dept. of Education at the University of Lowell, MA. He was the Director of the Brookline Early Education Project in Massachusetts and assisted in the implementation of the state wide parent education and support programs based in the public school systems in Minnesota and Missouri.

(*Pierson*) When driving here on Sunday, I recalled that it was just fifteen years ago today, November 1, 1972, that I began the position in Brookline as Director of the Brookline Early Education Project. It seems like we were all kids then and, still, here we are struggling to get early education started.

I will organize my remarks under five headings: Rationale and Background Information; Major Components of the Brookline Early Education Project; Highlights of the Findings; Discussion of the Minnesota and Missouri programs; and finally Conclusions and Implications.

Rationale and Background Information: The Brookline Early Education Project was initiated by Superintendent of Schools, Robert Sperber. His interest in the preschool child was stimulated in the late 1960's by the writings of McVicker Hunt and Benjamin Bloom, and Burton White. These psychologists all emphasized the potential for learning in the early years.

Dr. Sperber was also concerned about reports from his school staff regarding the growing numbers of children requiring special education. He noted that changing family circumstances, with increasing numbers of working mothers and single parent families, were altering the learning environments in many homes. The Town of Brookline is surrounded on three sides by the City of Boston. While the Town has a long history of quality education, it is taking on increasingly urban characteristics with housing projects, apartment buildings and condominiums replacing single family homes. Dr. Sperber questioned whether continued disproportionate expenditures for older rather than younger children was really the wisest investment plan for this school system. For instance, he depicted the school budget as an inverted pyramid in which nothing is spent before age five; expenditures then increase gradually so that in the secondary school years expenses are highest. This is because the high school lab equipment is more expensive, more secondary teachers have advanced degrees and hence higher salaries, and specialized classes such as foreign language and advanced placement are typically small. Therefore, the per pupil expenditures are approximately one and one-half times greater in the secondary years than during the early grades.

In the 1970's, Brookline already had a half-day kindergarten program, but Dr. Sperber began wondering whether schools should start with 4 year olds. At this time we received an anonymous grant of $1,000 to use at his discretion to benefit the Brookline schools. He decided to hire Burton White as a consultant for advice on what approaches would be helpful with regard to early childhood education and, particularly, the advisability of programs for 4-year-olds.

Burton White's advice, in a few words, was "It would be a mistake to start with 4-year-olds; you should work with families during the first three years of the child's life." Consequently, the Brookline schools began considering more comprehensive, ambitious possibilities. Dr. Sperber invited Dr. Julius Richmond, Psychiatrist-in-Chief at Children's Hospital and former national director of Headstart to bring medical colleagues and participate in planning for a national demonstration project. With Dr. Melvin Levine as the lead representative a close collaborative relationship was formed between Brookline educators and Children's Hospital physicians. The physicians recognized a need for incorporating developmental pediatrics into their training and for exploring ideas toward a model "early school health" program.

For a year the group was stymied in efforts to gain funding at the federal level. The federal projects were targeted only toward specific handicaps or impoverished children, and could not be used to serve a broader section of children. Eventually, the Carnegie Corporation of New York and the Robert Wood Johnson Foundation agreed to jointly fund the amount of $750,000 for a two-year pilot study for a longitudinal program. I was hired as Director with the aim of working with school, medical and community advisory groups, developing project guidelines and to begin enrolling families by the spring of 1973. The intention was to develop and administer a one-time demonstration program from which state and community agencies could derive their plans for ongoing programs.

The timeline was very unrealistic: the funding started November 1, 1972 with a commitment to begin enrolling families March 1, 1973, with essentially no research design but with a commitment to develop one. It was clear from listening to parents early on that there was no way we could exclude some of the eligible parents to be a randomly selected control group. It just was not politically feasible. It was also clear that there would be so much diffusion within the town there could be no randomly assigned control group. The approach that we arrived at was to try to follow, so far as possible, non-contemporaneous comparison groups to follow children of one, two, and three years old that were born before BEEP would be offered and to also try to answer in a cost-benefit kind of way what degree of services one needed to provide including how intense did the education for parents have to be in order to make a difference for children.

In the course of many planning sessions, seven guiding principles evolved as a framework for the project. These principles reflected several factors: our interpretations of the available research; our inferences from the opinion (sometimes conflicting) of authorities such as Burton White, Ed Zigler, Berry Brazelton, Bob Haggerty, Urie Bronfenbrenner, Bettye Caldwell, James Gallagher, Jerome Kagan, and David Weikart; and our collective experience in administering education and health care programs. These principles were:

1) Importance of the Early Years — Beep should help parents, school personnel and health care professionals to recognize conditions that influence learning in the early years of life. The efforts should not, however, try to force or accelerate development.

2) Primacy of Parents' Role — The aim should be to support and strengthen parents in their roles as teachers of the young child.

3) Relationship of Health and Development to Learning — Primary care givers should be partners with educators in advising parents and in recognizing the inextricable ties among health, development and learning.

4) School Based — To reach the largest number of children and for the sake of continuity, the elementary school should be the base from which the early education program is administered.

5) Open to All Families: Recruited Volunteers — To avoid the potential stigma and deficit orientation of serving only at risk children, the program should be open to all families; strategies should be developed to attract families who are unlikely to hear about or volunteer for such an innovative program. I was par-

ticularly impressed by the book *Pygmalian In the Classroom* that described the power that teacher and school expectations had upon the performance of children. I was also aware of how much difficulty you can have when you try to integrate into a regular classroom children who have been in a segregated special education program. So we accepted the challenge of trying to make it a program available to all children, yet at the same time having a commitment to reach out to families who had neither the traditions nor the confidence to seek out the opportunity themselves.

6) Continuity — Information and support to the family should begin prior to the child's birth and continue until the child is enrolled in the elementary school program. The program should focus on understanding and providing optimum learning opportunities for the developing child. You can't stop at kindergarten. It has to be an integral part of the total program.

7) Staffing — Team Model, Personalized — A written curriculum should be developed for quality control and program replicability. The curriculum should be grounded in an ongoing in-service training program and a flexibility to respond to family interests and needs. By a team approach I mean that we were concerned about the staff's owning individual families and we wanted to have the notion that two or three heads are better than one.

Components. The program was open to any resident of Brookline who was expecting a child to be born from the Spring of 1983 through Fall of 1984. To gain more diversity than would be possible in Brookline alone, the program was also open to any minority resident of Boston. Consistent with the school department's commitment to the state funded METCO desegregation program, the Boston resident children who participated in BEEP would later have the option of attending school in Brookline.

We set an initial target of enrolling 285 children (1/4 to 1/3 Boston residents), anticipating attrition of about 10 percent per year. This was the annual turnover rate in the elementary schools as well as in the area pediatric practices. Our seven year goal when the children would be in second grade, was to retain a minimum of 100 participants in the Brookline schools. We felt 100 would be significant enough for policy purposes, and it would also suffice for statistical analyses. Every conceivable means was employed to recruit prospective parents. Posters were left in parks and maternity shops; brochures were left with pediatricians and obstetricians; notices were sent home with kindergarten, Head Start, nursery school and day care children. Pediatricians tended to be very cooperative whereas obstetricians were less interested. Overall, the most effective recruitment came from informal referrals by satisfied participants; families who began to participate told their friends and the recruiting problem thus solved itself eventually. But until the program's reputation was established, particularly in the lower income neighborhoods, it was necessary to actively recruit families. It was hoped to have space for the drop-in center at one of the elementary schools but for about three years or so we had to rent space. The space for the first two years was in an obstetrician's office which was a home right in the center of Brookline. The aim was to encourage families to visit the center and to learn about what the program had to offer because it was complex and a new idea. No family that visited declined to participate.

We were able to substantiate that the families who enrolled roughly represented the demographic characteristics of the eight neighborhood school districts in Brookline. In addition, we were able to achieve the goal of about one-third minority families.

The services were organized into three program components: parent education and support; health and developmental monitoring, and early childhood education.

The parent education and support was relatively complex in that for purposes of cost analyses, we operated three levels of service. During an orientation visit families heard about the randomly assigned levels. The most intensive level of parent education and support would involve home visits once every three or four weeks, plus parent meetings at the same interval at the center as well as unlimited access to the neighborhood center. The moderate or middle level of investment involved home visits about once every five or six weeks, parent meetings at the same interval, and the drop-in center. The minimum level could offer only the drop-in center with no outreach component. Due to the randomization requirement, parents were required to decide whether to enroll prior to a level assignment. Some were unhappy about this complexity because they had strong preferences for more or less contact than might be offered. However, to our knowledge no one declined to participate because of their assigned level.

The aim of the parent education and support was to help parents become well informed advocates for their child's health and education. The home visitors and group leaders were called "teachers." As a school-based program, we intentionally chose that term to encourage identification with the schools and to influence the nature of the elementary teacher's role; we hoped to demonstrate that it was appropriate and helpful for teachers to be supportive of parents and to encourage family participation in schools.

In addition to a background in child development, our teaching staff were required to be parents of young children themselves. During the planning phase, several had advised: If you are going to send someone into our houses to talk about child development, don't send some bright young graduate student at eight o'clock in the morning to talk about Piaget when we have been up all night with a screaming baby. In retrospect, that requirement was most instrumental with developing rapport with parents. We also tried to assemble the same diversity of ethnic, cultural and lifestyle differences in our teaching staff as in the families, Black, Spanish-speaking, Chinese, Anglo, single parents, etc.

The home visits and parent groups focused on understanding normal child development, on developing networks of people who cared about and assisted each other, and on developing a sense of community, a sense of belongingness into the town. Continually, it was necessary to clarify, for staff and parents, that we were not training parents. The approach rather was to inform, to empower and to encourage self-sufficiency. We knew that it was much too presumptuous for us to propose that there was any single model of optimum parenting, that in most cases for any single issue there are a range of possible and legitimate responses. However, in most cases, certain parent behaviors are more effective and satisfying than others.

For each home visit, the teacher did have a specific plan, with written goals and guidelines. At the close of the home visit teacher and parents discuss the agenda for next time. Occasionally, the interests and needs extended beyond the purview of education, particularly when stressful issues impeded family functioning; e.g., martial conflict, inadequate housing, unemployment. Our policy was to acknowledge the critical importance of addressing such issues but, through staff team meetings to seek guidance and referral to appropriate community services, reserving the teacher's time for attention to her area of educational expertise.

The drop-in center was staffed by a teacher with graduate students from Wheelock College as assistants. It was an attractive, cheerful environment with many toys and books. Parents were encouraged to come in at any time with the entire family, including grandparents. Friday afternoon was a popular time, particularly if it was a rainy day. The Center was open six or seven days a week. We consistently tried to find ways to get fathers to be involved and organized many activities specifically for fathers. In fact, I personally conducted Saturday morning workshops for fathers and convened drop-in times for fathers and children. Nevertheless, we found more often than not, that mothers took major responsibility for the child rearing responsibilities, even when working. Fathers served a gatekeeping role, participating more at the outset and when concerns arose.

Choice of the term early education for this project created some confusion because, to some extent, it was a misnomer. Some inferred a goal of trying to accelerate or force development when, in fact, the thrust was to enable parents to foster an optimum learning environment. For instance, with regard to reading, books held a prominent place in the early education center, and parents were encouraged to read to their children every day. The aim, however, was not to teach children to read before kindergarten. We tried to assemble in the center some things that would enable "exploration" in areas that parents might not have at home. Grandparents were encouraged to come in, the entire family constellation was encouraged to participate. Several parents said it was a relief just to know that I can go someplace and know that someone won't be upset if my baby is crying, or to go someplace just to relax with a cup of coffee where someone else is there to help me watch my child. We tried to assemble the furniture and equipment in a way that would provide informal modeling for homes. For instance, avoiding sharp edges on furniture, arranging kitchen cabinets in a way that the utensils in the lower cabinets that children often play with can just be thrown back in the cabinet when the child finishes playing with them. Also, the staff could serve as informal models for consoling children or managing conflicts between siblings, encouraging sharing, etc. When the children reached three years of age, the parent education component shifted to a school base. In lieu of home visits, guided classroom observations were scheduled at the same frequency. These observations were less expensive than home visits and encouraged informed school involvement.

The health and developmental component was conducted in collaboration with the Children's Hospital Medical Center. A public health nurse and pediatric fellows were trained to administer health and developmental exams at periodic ages: 2 weeks, 3 months, 6 months, 14 months, 24 months, 30 months, 42 months, and entry to kindergarten. The aim was to ensure that no child entered kindergarten with an undetected health or learning handicap. Vision, hearing and dental screening were integral parts of the exam. The most important part of the exam, however, was at the conclusion when parents had time to discuss the child's development. Parents repeatedly said that, while they often had questions for their family pediatrician, they felt guilty taking the time because there were so many people sitting in the waiting room or they felt stupid asking questions which might have obvious answers. In this environment, parents felt comfortable asking questions and getting reassurances about their child. The family pediatricians received a written report following the exam, and parents were encouraged to pursue any concerns with the primary care taker. Our role was to help generate ideas, information, support and encouragement.

The childhood education component began when the child reached two years of age. During the 1st two years of the child's life, parents could come to the drop-in center and leave children supervised for limited periods (a couple of hours) at a time. At age two, weekly play groups were organized for groups of six to eight children. At ages three and four, a daily prekindergarten program was offered. This is the only component in which parents were expected to share the costs, paying from $25 to $800 per year on a sliding scale fee. The curriculum was modeled after the High/Scope Program in Ypsilanti, Michigan. Planning time for teachers, for parents and for children was a central theme. Classrooms were organized to foster self-directed yet cooperative functioning, and both cognitive and social competency. The activity areas had labels and tags so that children could see how many people could fit into an area, encouraging responsibility and independent functioning. Language learning in the form of modeling and language interaction was a key part of the curriculum. Children's work was prominently displayed throughout the room.

Partly because of the expense of the home visits, partly because that for so many working mothers it would have meant evening visits (which we did do), and also because of our growing concern for helping parents to be advocates for their child's progress in school, we shifted the parent education individual contact component from home visits to center-based visits when the child was age three. We maintained the three group levels at the same frequency, but parents were scheduled to come into the classroom for guided classroom observation in which they were expected to meet briefly with the teacher beforehand to hear what was going on that day and what the teacher's plans were. The parent was expected to watch his/her own child and then to have a time either immediately after class or by telephone later that day or evening to talk about what they had seen, to share observations, and to discuss how the child's experiences in school corresponded to experiences at home, etc. This proved to be a very important component, I think, and we were very pleased in hindsight with the plan to make that shift.

One of the main challenges throughout was to maintain the funding. Originally, the two private foundations made the commitment for two-year funding with the understanding that then it would be our responsibility to find other resources. One of the real drains on my time and a frustration for everyone was worrying about this. The school committee at the outset made it clear to the superintendent that they would not pick up any funding until there was evidence that it had affected performance in school. Because of this we spent much of our time each year writing proposals, making telephone contacts, making visits to Washington and New York seeking other funding, and ultimately going back to Carnegie and Robert Wood Johnson who would send in an independent team of advisors and evaluators to advise if it was worth continuing again for another two years.

Results: Throughout the project we asked parents at frequent intervals, both with questionnaires and independent interviews, to evaluate the project's components. Some parents told us they liked everything about the project except so many questions about whether or not they liked the program.

Figure 1: Parents' Ratings of Program Components

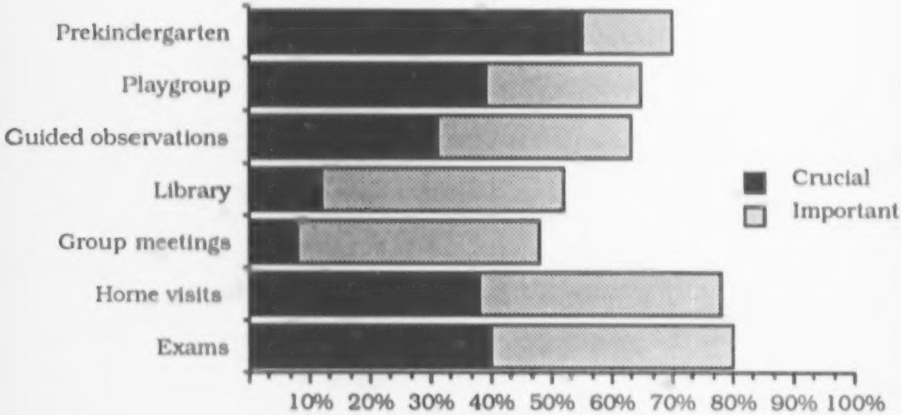


Figure 1 shows responses to a question to rate the program components as "crucially important," "important but not crucial," "nice but not really important," or "unimportant." The figure depicts the first two categories, with the solid bars showing the percent that rated the respective components as "crucially important" and the clear extension adding those who said it was "important." It is noteworthy that the daily prekindergarten received the most ratings as "crucially important." When we talked to parents early on about why they would be willing to enroll in an early education program, it was because they wanted child care or a prekindergarten program. Very few parents spontaneously expressed interest in parent education and support or in the health and developmental exams, although the health and developmental exams were also highly regarded.

Perhaps, the main insight gained from this survey, and it was reinforced when Heather Weiss conducted an intensive process evaluation with a cross section of 45 families, was that no component is crucial for all families. Rather, the reassurance, the validation for the role of the parent is the essence of any component, and different parents found this in different ways. Some obtained it from their child's teacher; others from the pediatrician or the nurse or the psychologist after the exams; some received this sustenance from their home visitor; and still others found it from networking with other parents. In one parent's words: "No one had ever told me before that I was doing a good job as a parent until I heard it here." A second theme that was gained in a variety of ways was the understanding and appreciation of their child as a unique and important individual, to gain some understanding of the rate of development, the wide range of normal development, and that no child is perfect. A third theme was the friendships that were developed. Many of the parents told us that even at the end of 2nd grade several of their closest friendships were those they had formed early-on. Parents whose children are now in 8th or 9th grade still tell me they maintain those friendships, even with some who have moved away from Brookline. It is surprising how many of those friendships formed early in the child's life were so important to them.

Effects on School Functioning: In considering the child outcomes, it is relevant to recall the diversity of the participants. The age of participating mothers ranged from 14 to 42 at the birth of the child; about 18 percent were adolescents and 20 percent were unmarried; about 50 percent were college graduates; about 40 percent of the children enrolled as BEEP infants were firstborn children and the range extended to one-tenth born. About 15 percent did not speak English at home. Thus, unlike previous studies of early education, the group included affluent as well as needy families.

At entry to kindergarten, a number of measures showed advantages for BEEP participants over comparison groups of children. The advantages, as documented in a 1983 article in Evaluation Review were more pronounced in social skills than in cognitive areas.

In following the children's progress to 2nd grade, two major measures were used to assess competence in school: classroom observations and teacher ratings. Martha Bronson developed the classroom observation measures based upon extensive pilot testing and work with elementary teachers on what they regarded as competence in school. The observations were conducted by independent, trained observers who recorded social skills and mastery skills. Social skills involved getting along with other children, being a leader as well as a group participant, and following directions from adults. Mastery skills involved such behaviors as working independently, completing tasks, and resisting distraction. The observations involved six 10-minute occasions for each child in the Spring of the 2nd grade year. Reading difficulty was measured by asking teachers to report the level of basal reader that children could comprehend in the Spring of the 2nd grade. As a criterion, we took not comprehending a 2-2 basal reader as evidence of having difficulty. In the Brookline schools, children in the Spring of the 2nd grade year who are not reading at that grade level tend to be assigned to remedial reading groups or special education, and the gap tends to grow greater rather than decreasing with time.

Figure 2: Percent Reading Difficulty

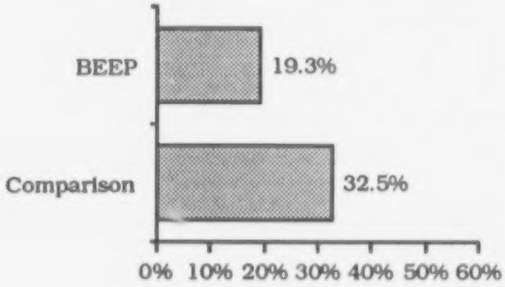


Figure 2 shows that the proportion of children (n = 169) in the comparison group who were reported as being below grade level in the Spring of 2nd grade was nearly one-third. The BEEP reading difficulty rate was about 20 percent.

One of the most important findings in our study is apparent when the proceeding data are analyzed by program level and by level of parent education.

Figure 3: Percent Reading Difficulty in Highly Educated Families

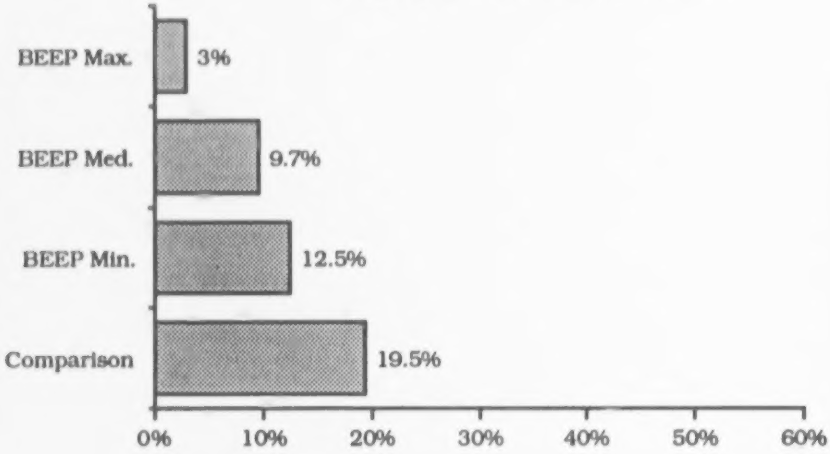
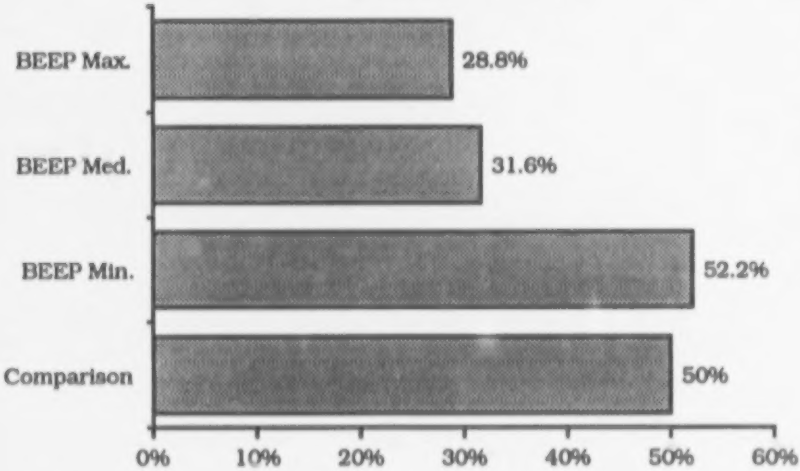


Figure 3 shows the percentages of children with reading difficulty for the highly educated families, operationally defined here as the mother being a college graduate. The baseline data indicated about 20 percent of this comparison group (whose mothers were college graduates) were having difficulty with reading at the end of grade 2. For families who received the minimal parent education (no outreach, just the drop-in center coupled with the health and developmental monitoring and the early childhood program) the percentage with difficulty was 12.5 percent. About 10 percent in the moderate services group had problems. Nearly all the children functioned at expected grade level in reading if they were in the maximum group which included regular home visits during the 1st two years of life.

Figure 4: Percent Reading Difficulty in Other Families



In turning to Figure 4, we consider the results for children whose parents are less highly educated. This revealed an especially significant finding for policymakers: an early education program with minimal parent education services (no home visits) shows no school performance benefits for these children. Families with great needs require more than the availability of a drop-in center, even if an early childhood program and a health and developmental monitoring are offered. However, for families who did receive outreach, the impact on children is significant but there was not much difference in effect between the moderate (home visits every 5 or 6 weeks) and the maximum (home visits every 3 or 4 weeks) intensity. These studies indicate that a carefully planned parent and early childhood education program can make a significant impact on children's functioning in elementary school.

The cost per family was originally targeted for the three levels of service at $1200, $800 and $400 per child per year. When we got into the early childhood daily programs those costs increased about $300-$400 per child so that the minimal model was operating at about $700-$800 per child per year. We did for the first time, at the preschool phase, charge a sliding scale fee for parents because we didn't want children to participate in the early childhood program only because it was free, and we were trying to operate what would be a feasible community model.

Long Term Effects on the School System and Community: Based on these and related results, the Brookline schools have incorporated several early education components into the schools. Two kindergarten teachers have been trained to conduct afternoon home visits with parents of infants, a bilingual home visitor visits the homes of limited English speaking children, a drop-in center with books and a toy-lending library is available for parents with young children. Parent groups are organized on early childhood topics through the adult education program, a bilingual playgroup for two year olds meets weekly, a bilingual prekindergarten class meets daily for three and four year olds, and three transition-to-kindergarten classes have been organized around the BEEP prekindergarten model. In addition, the Public Health Department now conducts sensory screening for families with preschool age children, and developmental pediatrics has become an integral aspect of pediatric training at Children's Hospital.

Probably the most important outcome of BEEP's work to empower parents is that the Brookline school committee now has three BEEP parents serving on it and that, more than anything, is what is ensuring the perpetuity of education in Brookline. The last vote to extend this increasing investment in early education was strongly supported by the individual who was initially the most skeptical. He was an outspoken, hardheaded businessman who early on had said, "Don't come back to us for the funds unless you show that there is cost benefit." Since he saw the data on reading difficulty, he's been up there every year putting in motions to invest more money in early education because we have to get into the prevention business.

Massachusetts has funded early education in a small way through its Education Reform Bill, Chapter 188, with a number of communities receiving early education grants to conduct pilot programs. The interest of Commissioner Raynolds in this field is likely to lead to further commitments. One of his key advisors is a former BEEP staff member.

Minnesota and Missouri Programs: In 1974, Minnesota state Senator Jerome Hughes visited the Brookline Early Education Project. A former teacher, Senator Hughes had read an article about BEEP in the New York Times and was convinced that Minnesota should have early education programs. He spent a full day in our Center, observing exams, talking to teachers and parents, and discussing alternative strategies for initiating early education in Minnesota. My advice, at the time, was to proceed cautiously, as we did not yet have results to report. Senator Hughes, however, was unrelenting. He said, "It's self-evident that early education is important, the time is now, I can get support for it, and we're going to go for it." He went back to Minnesota and filed legislation to create a Council for Quality Education with the Department of Education. The primary mission of the Council was to support school-based pilot programs in early education. They could not be just day care programs without parent involvement, but other than that restriction most any other model was legitimate. Pilot projects were started in six school districts. Each year parents who participated were so enthusiastic they would stand outside of the State House when the bill was filed to support and to increase the amount of money funded each year. They brought their babies with them and who is going to deny mothers standing with babies in Minnesota outside the State House. Starting in 1975 with six schools, early education has gradually expanded to a statewide program with current total funding of $20 million. Three hundred school districts out of the 425 in Minnesota now choose to participate. This represents 24,181 children between the ages of birth and five years. Programs vary based on local plans but all require participation by parents and none include daily child care. The common features are: early health and developmental screening, parent and family education, discussion groups, parent and child guided play, lending libraries, special events, and information on related community programs. Standards of good practice have been published and school coordinators must attend training workshops. The funding amounts to about $50 per child on an individual school basis, and schools are encouraged to supplement the state funds either by local levy or through fundraising.

In 1982, the state of Missouri, followed Minnesota's leadership role in early education. Governor Bond set early education as one of his priorities and appointed a task force to work in developing plans. Initially four districts embarked upon a pilot program to offer education for first time parents. Starting with 380 children, the program had two main components: hearing and vision screening for one and two year olds and home visits in the Parents as Teachers Program. That program has grown on an annual basis and current Governor John Ashcroft, has set as his top priority statewide parent and early childhood education. He has persuaded the state legislature to commit $11 million for the Parents as Teachers Program, and every school is now mandated to offer a program that includes screening for one to four year olds. This year approximately 43,000 children will receive screening as one and two year olds; 72,000 more children will receive screening for three and four year olds. This represents, respectively, 30 percent and 50 percent of the eligible population. The Parents as Teacher Program includes monthly home visits and now involves 54,000 families for one and two year olds as well as about 55,000 families for three and four year olds. The Missouri program has thus grown enormously in the past four years. The state investment averages $164 per family with school age children. Local schools invest an average of $67 per family. Districts may contribute, add to or supplement, the state levy but they may not charge fees. Ed Zigler is now the Chairman of Missouri's Advisory Committee for Parents as Teachers. Monthly staff training sessions and intensive summer institutes are conducted for all sites.

Conclusions: I shall close with a brief list of six issues that should remain in the forefront of considerations for future early childhood programs.

1. *Program Goals* — The importance of having clear, simple goals that are meaningful and responsive to parents interests and needs, meaningful to state and federal policymakers, yet comprehensive in scope.

2. *Selection and Recruitment of Families* — The value of a community-wide approach that avoid a deficit model, which I think is so essential, yet at the same time build in the capacity for recruiting families who will not seek out a program that is entirely of a volunteer, community-wide nature.

3. *Health Screening and Developmental Monitoring* — This is an integral component but doesn't have to be based in the school. The program could well be administered under the aegis of a pediatric health center, such as the kind of initiative that Steve has described in Maine.

4. *Evaluation for Cost Effectiveness* — Expensive longitudinal research is no longer needed to justify the plausibility of early education; continual assessment is useful for quality control.

5. *Staffing* — The selection, training and supervision require careful attention and budget consideration. The quality of the staff will in large part determine the quality of the program. Insofar as possible, have the staff mirror the demographic characteristics of the families being served.

6. *Continuity with Elementary Schools* — To foster a long term impact on children and families, local educational agencies must be involved. I would argue very vigorously that parent and early childhood education should be delivered within the local communities by whatever agency is most ready to deliver it. The school, just as all of the other caregivers, needs to be a part of

that and, in the process, transformed to be more responsive to the needs of children and families.

Returning to the question one of you raised about the theme of what do we want children to be: I think you said, "happy, healthy and nice." In terms of relating that to policy considerations, I'd suggest reordering it to: first, healthy, in that families when they are expecting the birth of a child, they are extremely concerned about a healthy baby and they will participate in the program if they feel they can get some reassurance about that. Secondly, when you get to the two year olds, you want a kid that's nice and you want some advice on how you can cope with this monster. So I think you can capitalize on that motive. Thirdly, everyone wants to feel their child is happy, and in the middle years, this will largely be determined by how well they do in school. Here the motivation is to help your child achieve academic and social competence and avoid the stomach aches and stigma of not being successful, whether in kindergarten, first grade or later on. In adolescence, it's how can we enable kids to be strong as peer pressures amount. Whether those can be catch words or not, it would be interesting to see.

I would like to conclude by reiterating a note I took from Ed Zigler's presentation. It is a thought worth repeating: "Let's help children become all they can be. That's enough of a goal for me!"

(*Chamberlin*) When you have a mix of teens, minority groups and different educational levels all together, how did that work out? Did you try to target programs more toward teens or particular groups or did you just let them all come and work things out as you went along?

(*Pierson*) We tried to individualize or personalize the program as much as possible. Regarding the discussion groups, we tried to encourage parent initiation. Often parents would arrange to get together informally or suggest a meeting topic. For instance, some of the Hispanic families really enjoyed the social gatherings; they frequently had parties with food, usually on Sunday afternoons. It was very difficult to engage the teenagers in discussion-type meetings. Most of the discussion groups were more popular among parents who were education-oriented. I wouldn't advocate investing much in organized parent groups. I think it is important to find ways to help parents to get together themselves. Most of the parents who benefitted greatly from the discussion groups were parents who would seek out those opportunities themselves anyway.

(*Chamberlin*) The reason I raise that is because when I talked to the health department in Illinois about why their program got changed into one for teen parents rather than for parents in general, the reason they gave was that you can't reach teens if you don't have special programs. You're saying you don't really have to do that; maybe you do for groups, but not for home visits and not for the rest of the program.

(*Pierson*) Right. I think we reached teens best through the individual home visits, through the guided classroom observations, but particularly through the health and developmental exams, because often these children were not receiving quality health care. Parents were required to come to the examination and that was a good opportunity for counseling, for bringing a social worker in at that time, etc.

(*Rubino*) I think you do need, to some extent, to have special programs for teens or special training for people who are working with them. Most people, by the time they are twenty, are not going through the incredible mood swings that teens have. If the parents you are working with are not teens, and there are a couple of teens in the group who start to do these bizarre things, I think people begin to think they are bizarre instead of recognizing that they're just kids. For most of our groupings, except for vocational training, the teens would usually only come if it was a group of other teens. They usually didn't feel comfortable talking about issues with old guys like us or other parents in the group like us who were perceived as old people.

(*Pierson*) I agree with the importance of carefully planning programs for teens and, particularly, with the importance of special staff training for people working with teens.

(*Q*) Did you have a substantial number of teens in your sample population to see if there were any different impacts for them than for older mothers?

(*Pierson*) The needs and challenges were certainly greatest there but the teens in the two more intensive programs with home visiting had some remarkable gains. In these cases, the mothers were able to complete high school. It was in those children that we saw the greatest gains, not just for the teenage mothers, but across the board. In cases where the mother's education level increased from the start to the close of the program, their children were also making the most remarkable gains as well at every level of parent education. This trend reinforced the notion of empowering mothers as parents and informed advocates for their children.

(*Weil*) I was recently at a conference in Michigan where another participant spoke about some research, indicating that when parents enter programs and proceed with their education at the same time as their child, there are significant gains for both. I wondered if anyone knew anything more about this.

(*Mitchell*) It was more specific to the level of program intensity and the level of program involvement. Where both are high, it tends to correlate with both the kids and the parents doing better.

(*Weiss*) I think there's a couple of things: Dr. Olds' study shows substantial gains for adults in terms of completion of school and getting off welfare. A child welfare research project in which Dr. Zigler was involved did a follow up and found significant gains for the adults with respect to a variety of different indicators. Some programs, such as PACE in the State of Kentucky, have begun to develop a simultaneous adult literacy, adult development and early childhood program, explicitly around active efforts to promote both adult and child development.

(*Weil*) I think it's ironic because many of the programs, including the ones Heather is talking about, are explicitly parent ed programs but they only measure child gains. The few that have measured adult gains, such as the Yale Child Welfare Research Project, even though it's a small sample, or Dr. David Olds' project, have found important gains for adults which suggests that intensive versions of these programs can have two generational effects.

(*Pierson*) I have to reinforce that point with one other piece of data that Penny Hauser-Cram collected. This was a follow-up study in 2nd grade, asking the 2nd grade teachers to record their contacts with parents during a several week period. Incidentally, a review of previous literature revealed that children whose parents initiate frequent contact with the school around their child's academic progress, do better in achievement than other children. The BEEP parents initiated twice as many contacts concerning their child's progress as did other parents. When parents were asked what kind of impact they thought the program was having, they said they weren't sure it was making any impact on their children. Some felt a vague notion that their children would be more successful in school but the main reason they were continuing to participate was because they felt that they, themselves, were becoming empowered — they had more information, more insights, felt more confident. For instance, minority children were assigned on a space available basis to schools and it was unheard of to protest that assignment in the early days of the program. One Boston parent's child was assigned to one grade in kindergarten and then, because that school was crowded, was to be shifted to another school for 1st grade. The mother went in, first, to the teacher and principal, then took it all the way to the superintendent. This was a young parent only about 20 years old. She appealed to the superintendent and persuaded him to let her child stay in the same school. Her participation in BEEP gave her the confidence to advocate for her child.

(*Weil*) I'm not sure what the figures are, but with Headstart parents they have been very successful nationally at advocating at various times to save that program. We've not used that very well at the state level because we haven't had to. Headstart has been federally funded so they've fought those battles at the federal level. But there is a real solid base of support that could be used at state levels among Headstart parents and we've got 20 years of people who are very good advocates.

(*Pierson*) But only those who have young children have a vested interest in early education programs, and I don't know how much you can count on it. I regard that as one of the difficulties for the constituency for early childhood. As children grow, families have new and competing needs. Maybe that's one reason for starting programs for families with very young children, so they will be constituents for three or four years continuing through kindergarten.

(*Mitchell*) We ran into this situation this year because we had to go to the state legislature. We had parents who had left the program six or seven years ago, come back and talk about what a crucial difference it made to them and how important it was that these programs be available to other parents and families. I bet BEEP parents would do the same thing even though they're children are in 8th grade now, because part of what happens in those programs is that people grow through helping somebody else. When you've gotten into that mode, then you realize you can impact the legislature, too, regarding that.

(*Weiss*) It's also an argument for setting up alumni associations.

(*Weil*) At the conference there was a terrific video that the State of Washington had done. They've passed Headstart-like programs. They got a TV station in Seattle that had done a lot of in-kind work with them, because they were trying to raise more Headstart money in Washington state. It was wonderfully done. They had gone into prisons, interviewed prisoners who had not achieved as young children, etc., and the last two people they interviewed were two former Headstart graduates, one a young black woman graduating from Harvard and another second year junior college, interviewed in the schoolyard of his former Headstart building. It was a wonderful note to end on. They had done a very good job of learning about marketing. Apparently, it was played two or three evenings on TV during the news broadcast.

(*Pierson*) Last night when I went upstairs I turned on the television. In an ad during the football game, I saw Roger Stawback talking about giving to the March of Dimes with a photo of a little poster girl, age five. He said that if it were not for the breakthroughs in March of Dimes research this girl would have been crippled for life. The camera flashes to the present — the girl is queen of her high school prom, Roger enters and introduces her now. He says, "Won't you give again this year and help more children like Charlene?" Can the case for high quality kindergartens and parent education be made in similar fashion?

References

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End of Second Session

WHERE DO WE GO FROM HERE?

(The Wednesday morning session)

(*Chamberlin*) Today, we're going to try and figure out what this all means. What should be our goal coming out of this conference? Where do you see us going from here?

1. Tri-State Collaboration

(*Mitchell*) So much information has been presented that in some ways it was a little staggering. Everytime somebody spoke you felt that was the area where we should be focusing. For me, the main current has been some of the newer ideas about social marketing, about ways of presenting programs so we're reaching wider audiences, and thinking about what's going on in our three states. I would love to see us continue some type of tri-state collaboration, but as far as trying to think about doing programs across the three states, it didn't make too much sense to me. In Vermont, we're working on five-year agendas in most of these areas and it would be hard to change the state at this point. But some of the issues that were brought up in terms of how to sell community-based prevention services to specific audiences and how to encourage community members who may not be using the support services to use them could be very useful.

(*Weil*) We should collaborate on some things, such as training and technical assistance across the three states. Each of us has goals and objectives we're working on. Charlie is talking about doing a model program in a community through an RFP (Request For Proposal). We're in a different place in Maine, but we have some common things related to community-based services that we're working towards. We could use some technical assistance and consultation in social marketing and research and evaluation. Perhaps we could build a way for people from our states to come together two or three times a year. If New Hampshire tried putting out an RFP in communities, we would learn from that by sharing. Those would be times also when we could get common training in some of the things we don't know so much about. The other idea I had was related to funding. If we were to try to get funding for this effort, we could make some kind of commitment to try to get some of what we were asking for from within our state, either our state legislators or foundations or whatever. Then we could ask the federal government or foundations we might be going to to match what we have raised internally.

2. Develop an Overall Framework

(*Jackson*) I think a basic decision the group needs to make is whether you want to change the way you currently do program work. Most of this is geared toward improving the way we do existing programs vs really stepping back and saying do we need to completely reorganize them, build a framework and then drop the programs within that, and then look at the picture. Because, for example, social marketing is very much to me way down toward the program planning process. There's a lot of community organization and needs assessment work that goes on before that. I'm not sure what the goals of the group are and maybe that's what we're trying to establish. It's a very different approach than saying we've got programs and we've learned some things here that we can apply to our programs. Another goal might be to develop a broader plan. For example, you mentioned earlier problems such as access to care, money for services, transportation, and adequate database, funding, etc. To me, those are important problems and coordination was one you really emphasized. But they are all sort of pushed together and, in fact, I think there's a way to drop them out and put them in a sequence of goals or a sequence of tasks that could be addressed by this group. So you deal with how you're going to coordinate activities and then fund them, and then get into program planning and the use of social marketing, etc. I think there's a need for a higher order, a bigger picture.

3. Develop a Model Program

(*Albano*) I know internally right now we've been doing child health for umpteen years the same way. We're seeking consultation to develop a six-year plan and the reason I wanted a six-year plan is based on the fact that state budgets are funded every two years so we have to start now to get something in 1989. But you don't stop everything until this plan is developed because it takes so long. What I'm thinking is can we do something that will be innovative and community based while we're doing our planning? We could pull out some resources, try a model program and see if that blends with our planning process, and then we can modify our planning around information as it comes in. This draft RFP I put together yesterday was a blend of what I think you want to see and then identifying the resources, which in New Hampshire are already there and it's a matter of just pulling them together with some kind of mandate.

(*Weiss*) It seems to me what we're saying is you have to decide whether you are going to tinker with business as usual or whether you are going to change the fundamental way things are done. Is that a fair statement?

(*Jackson*) Yes, recognizing that there's a full range there, and I realize you probably can't change the way things are done, but the emphasis can be in one direction or the other. What you are saying is that you would develop a pilot plan and get it going, so that when there was a chance to do it in a full blown way, you'd have the experience to help you implement your new plan in a larger way as time went on.

(*Albano*) The first year of the first two years of a six-year plan may be to do some things. The second year would be to do some others. For the third year, maybe the goal could be to use ten percent of the existing contracted money for the development of two or three special projects. The middle years would be an evaluation process. So that we're thinking about getting money, and we're not quite sure how to use it, but we can start this project and keep it moving even though two years may not be enough to analyze and evaluate it. I think sometimes we evaluate, analyze and think too long. I'd like to be more active, do something, even though it's wrong, but do it, learn from that, fix it, then keep on going. I don't think we have to wait five years to do something; I think we could do something pretty quickly if we have the right players in place.

(*Weil*) I think the beauty of doing this on a three-state basis is that we are all in different places. One state might be very much more in the mode of being able to say if we want to do something ideal, what would it be? Then beginning to put that into place: New Hampshire may be ready to put out an RFP to try out a community-based prevention program. In Maine, we're more in a position of wanting to tinker with what we have. We've got a structure that needs improvement. We know what some of those improvements are, but we're not going back to point zero and start planning all over again. From a funding point of view, I think that would be a nice mix of different things going on in three similar states, with a lot of collaboration and cross referencing going on.

4. Change the Orientation of Health and Human Service Systems

(*Chamberlin*) I can give you what my agenda is for the big picture change. What I'm trying to do is to move the health and human service system toward a comprehensive, coordinated, community-wide, non-deficit oriented approach to the primary prevention of maternal and child health problems related to family functioning as defined by health habits before, during, and between pregnancies, and parenting skills after the child is born.

(*Jackson*) That's the difficult part of it, because I don't really know that much about maternal and child health issues. What I haven't seen at this meeting, and maybe it's in all of your heads, is the last part of your very long sentence. It makes it sound like there is a coherent package of services and needs, if you will, maternal and child health needs, around the family. What is that? That's what I don't understand. It seems to me that if you had a big vision of what that would be, then you could objectify what you have and put it on paper and say we are meeting these needs. I'm not talking about alot of major planning; I'm just talking about looking at what you have within a broader picture. That's going to give you guidance as to what else you need and how to pull together what you currently have, and to draw links that are not currently there between existing programs, for example, and coming up with a unified approach so that it is a single package. The way you describe it, it is a single goal almost.

(*Chamberlin*) Yes. It's strengthening families because all these maternal and child health problems are related to family dysfunction. It seems to me we know an awful lot now about how to strengthen families in terms of a number of different programs. What we don't know is how to put them together in some kind of coherent and affordable way and sell to people that it makes sense to do that.

(*Jackson*) Right. And it's discussion based on all your experiences on how to pull it together in the coherent package, so you agree on some sort of common vision. That's important because that's what drives you where you go.

5. Develop a Framework in Terms of Developmental Stages

(*Berry*) What I've gotten out of this, which is something I already knew but it's reinforced that, is that our MCH program is set up to describe what we have done and currently do. It isn't set in a framework of goals. I just drew up some goals for different life stages. For example, in the preconception stage, it is every child a wanted child, which is an old goal of Planned Parenthood. But there should be a database that tells us whether we are reaching that goal, like an abortion rate, for example. I think the database comes after the goals and, certainly, in our MCH programs we don't have well articulated goals. Then there's pregnancy. The goal would be to maximize outcomes of pregnancy, and that's probably the strongest database we do have. Then, that newborns should be healthy during the first year of life.

(*Chamberlin*) I see all of those as social indicators of family health. It seems to me that if you're getting alot of problems in those areas you know that families are floundering in that community and, therefore, you need to plug in all these services. I would use them as need indicators to identify communities you want to come into with your programs because they are all related to family dysfunction. Does that agree with what you are saying?

(*Berry*) I guess the first thing is to establish goals.

(*Chamberlin*) What do you see as an overall goal?

(*Berry*) I broke it down into life stages rather than an overall goal.

(*Chamberlin*) OK, so the stages you see are prenatal, infancy, and then. . .

(*Berry*) One to Three. It's up for discussion how those get broken down, but right now I was thinking one to three, four to five, and then. . .

(*Chamberlin*) Under ones?

(*Berry*) Yes, but before that is preconceptual, or whatever you want to call it.

(*Chamberlin*) OK. One of the problems with building a database is that there isn't any uniform way of breaking it down into stages and everybody does it differently. One of the goals I see in collaboration across states is to develop some kind of a common database so we can compare rates for child abuse under five, and things like that.

(*Berry*) First, you have to agree on what the indicators are.

(*Chamberlin*) What other stages do you have?

(*Berry*) I said four to five, then school. I didn't carry it out any further.

6. Establish a Uniform Database

(*Chamberlin*) I guess I would put it as under fives as a lot of literature is beamed in at that. Then I would make it five to fourteen, then fifteen to nineteen. It seems to me that there are a number of social indicators for teenage malfunctioning and there's a lot of indicators for children under five that suggest family malfunctioning, and the 5 to 14 year olds are an in-between stage between the two. If I were proposing a cross-state database, I'd break it down into these age periods and then try to get all the different agencies that are involved with problems to begin to report in terms of those age periods so you could tell what the needs are in your state and whether your programs are having any influence on them over time. That seems to me one of the basic things we need to do.

(*Weil*) It will take a long time to get there. Coming back to it from a funding source perspective, it would be an interesting and positive goal to have the three states do that. I think it will take us a long time, probably first of all among ourselves to define what we think the indicators are and what the age ranges should be, then going back to our states and getting agreement to collect data in certain ways, then having to convince the people who have to report the data to do that. I think it would probably strengthen a plan that we're putting together, with that as a long range goal for what we'd like to do across the states. I would hate, however, to see us get bogged down in that as a first step, except for maybe defining the indicators, but even that is a big task. I think it's a good long term goal, however.

(*Chamberlin*) How do other people feel about that?

(*Albano*) I think if you connect with the Vital Records people about that you are going to see where the natural breakdowns are.

(*Chamberlin*) Vital Records doesn't have it broken down that way, and that's half the problem. I tried to get the data for kids hospitalized under one because that's a problem related to family dysfunction that's well documented in the literature, but I couldn't get the information I needed.

(*Albano*) I know that. We can't get it for injury. What I'm saying is to look at what each state does have across the board, then use that as your starting point.

(*Weil*) I think we can take what we've got and then see what else we can get them to collect. We got Vital Statistics in Maine to collect things they didn't collect before, but they've got a lot of information.

(*Chamberlin*) But it's all in different forms so you can't use it to evaluate your programs very well.

(*Weil*) You should be able to use some of it. In our state, it's broken down by counties so you can look at some things like birth information by counties, infant deaths by counties, and cross compare that. If all of our states collect certain things by counties, I'd rather work with them and give them positive feedback for what they do collect when asking them if they'll collect some other things as well.

(*Weiss*) What are the things that change people who collect vital statistics data?

(*Chamberlin*) You have to do it from up high, get the Commissioner to say all you agencies have to get together to come up with some uniform way of looking at what's happening to families in the state. The Commissioner or legislature have to do it, or the Governor. If that happens, it will be done very quickly; if you try to do it from the bottom up, it's going to take forever. At least, that's my experience.

(*Weiss*) If you have a program in a state that's getting some visibility and some national play, then you have to say we can't really evaluate this because we don't have X. Won't that motivate some of the higher ups to make some of the changes?

(*Chamberlin*) Not necessarily. You weren't here when our Commissioner was reporting on what is happening in N.H. She paints a fairly rosy picture because the Governor wants things presented in positive terms rather than by bringing up a lot of negatives about the state. So, if you're going to depend on political appointees to tell you what's going on, you're going to get a very distorted picture. The Governor has a vested interest in making things look good.

7. Establish Child Oriented Goals

(*Mitchell*) I find Patricia's outline appealing. I hate to be simplistic about this, but I think we could say the two outcomes we're looking at are happy and healthy. We can then look at, for each stage of development, what needs to be in place in different communities to do that. Around the health issues in that whole preconception period, it helps us to focus on nutrition and access to comprehensive health care services for adolescents and for people. Then we know that family planning needs to be in place if kids are going to be wanted kids. We know what needs to be in place during the pregnancy period if we're going to have healthy pregnancies, both with the mother and the developing child. Basically, if we look at the health issues, we know what needs to be in place across those different life stages, and we also know how to do it, I think. The more difficult one is the happy one — and I'm willing to can nice (probably you're not going to be happy if you're not nice) — but then that brings us into what needs to be in place around support services for families. We know pretty much the kids are not going to be happy unless they're doing well in school and we know that most people are not going to be happy unless they have some kind of functional vocational competence. The one that we don't know as much as we need to know about is mental health: what the mental health issues are.

(*Weil*) And that really straddles the healthy and happy. The happy things can get you into alot of the social competence, psychosocial, emotional sorts of things. Mental health may be the thing that straddles the two, and is the one we know the least about.

(*Berry*) We should have an overriding principle of community based prevention programs. Because without it, for the Children's Trust Fund, for example, everybody sends in a proposal and people sit around and say "that's nice" and "that's nice," and there's no framework. I know it's going to take time and that's fine with me because I think what has been helpful is that now, as opportunities come about, you at least know where you're going. I think that's happening all the time and things are growing like topsy, in terms of MCH anyway in Vermont, and I doubt its much different in the other states.

(*Chamberlin*) And without any set direction, it's just a bunch of things coming together in a haphazard way.

8. Use the Overall Framework to Assess Community Needs

(*Mitchell*) I think its starting to be more directed. I think it's this kind of grid we've been looking at: here's what happens in the life stages, the overarching goals, these are the ways that we get at them. It is difficult in most of our states to have a comprehensive vision of that because some things are going on in the local community, some things state government is doing, some things are being done as a pilot here, here and here, whereas other things you can depend on having available in each community. But it does give us a way to look at our communities and say, OK, everything is in place in this community, although it may be provided by six or eight different players working together. In another community we can say these things are missing or because the people won't work together the services are basically not there — technically they may be there but effectively they are not there because the groups don't work together, and so they are not available to a family.

(*Chamberlin*) Does this meet your criteria for developing an overall framework?

(*Jackson*) I don't know. Can I draw a picture?

9. How Do We Define Community Wide?

(*Weiss*) Can I raise a question? I'd be interested in how people are defining "community" and "community-based" and all the rest of it.

(*Chamberlin*) I want to get to that because I think "community-based" and "community-wide" are two different things and the differences are important.

(*Weil*) I think of it in different ways. The little town I live in, about 1000 people, is a community with probably social services only through the school. Having enough people to serve economically, I think, is one criteria. I tend to think in our state of counties because they are fairly well established in peoples' minds. There is usually a central city or town that is the hub for a variety of kinds of services. The state is used to dealing with the counties in a variety of ways. In the cities, it's more complex because those counties, like Cumberland Co. in our state where Portland is located, operates really for certain things that are within the city and certain things that are for the rural areas of that county.

(*Chamberlin*) So, sometimes you have to break counties down to less than just the county.

(*Weil*) I'm sure in other states that's very true where there are bigger counties.

(*Chamberlin*) When you say something is community-based you mean it just sits in a community or . . . ?

(*Weil*) No, I mean the things I think of as functioning in a community-based way usually have some kind of outreach component to them. They don't just wait for people to come to them.

(*Chamberlin*) It would cover a defined geographic area?

(*Weil*) Yes.

(*Chamberlin*) And it covers all eligible people or segments?

(*Weil*) Depending on what it is. It covers segments or eligible people by means of . . .

(*Chamberlin*) That's the difference I see between community-based and community-wide. Community-wide programs cover every eligible person in that community. Community-based services are usually focused on various high risk groups.

(*Weil*) Then that's what would be more ideal, the community-wide. I think what we've got a lot of is community-based.

(*Weiss*) When I think of community-based it has a geographic component, some physical entity. I usually add to it that it is community-wide, not that there's the same service to everybody but there's access to a set of services within a particular area on a community-wide basis.

(*Chamberlin*) Things are accessible to everybody.

(*Weiss*) Yes. I realize as we talk I also bring ideological baggage with respect to its being community-specific, and having a great deal of community input with respect to decision making, with respect to client feedback, and with respect to ownership of the particular set of things, even if its coordinated in some kind of larger state system. There's a sense of intensive and ongoing community involvement, there's a process that's been set up that maintains that, so that there's ownership at that level.

(*Chamberlin*) And then you begin to worry about size in order to do that.

(*Jackson*) And that's what we were talking about yesterday; how high can you go and still hold on to that community-based notion. We use community-wide to refer simply to geography. The notion of whether its community-wide or not is driven by at what level do you have that sense of ownership and shared vision of shared goals.

(*Chamberlin*) The Scandinavian countries I visited defined that between about 6,000 and 20,000 although in some big cities they break it down into larger segments, but 6,000-20,000 people is the size range for most basic health and social services. Catchment areas for specialized services such as hospital care are much larger.

10. Can We Modify the Stanford Model to Fit Families and Children?

(*Jackson*) I think one of the differences in our program is that the problem is not developmental. Whether you are working with fourth graders or 55-year old people, the message is the same basically, the behavior change goals are the same, and the predictors both at the individual and environmental levels are the same. It seems to me that what you have is a situation where individual factors, like whether a woman works hard and stands up a lot, etc. is important at one stage but it's probably not important at another stage. At a given point, something else becomes important in terms of predicting negative outcomes at different stages. So, I think what I would need to pull together a coherent plan is to learn from you what are the different stages we've talked about, then, moving back from there, what is it in terms of individual belief structures, what kinds of knowledge do you think people need and what kinds of skills do they need, etc. in order to do well and avoid these outcomes. Then, moving back from there, what sorts of policies and organizational variables and sociopsychological variables (family, traditions, etc.) increase these individual level risks?

(*Chamberlin*) So you're looking at these as the kinds of outcomes we're trying to prevent.

(*Jackson*) Yes. I'm imposing the model that I gave you the other day called an ecological orientation which involves looking at multiple levels and the surrounding environmental factors that affect individual risk, and therefore this negative outcome at "stage one," however you define that. What's unique and what's more difficult about your situation is that this keeps changing as people move through the system. I think without this sort of overall picture, and I think you could fill this in pretty quickly, you don't have a clear picture for a "community resource inventory," which is where we look into the community to see what's out there that's positive and negative in terms of affecting these outcomes for driving needs assessment and for driving evaluation. But you also need to know where people stand, and this will help you with the social marketing, because you need to know where people stand with regard to existing beliefs and existing levels of knowledge and misconceptions. Also, you need to know what's going on in terms of further down the line: for example, availability of contraceptives, laws at the policy level regarding abortion, and all sorts of things that are policy level, organizational, and social level variables. I think a lot of what we try to accomplish we can't really do without this kind of global picture. I'll talk about heart disease because I don't really know what's going on here. At the social level, we look at things like family tradition (see the model on page 82), social level variables, parental behaviors, etc., things that influence individuals. So, what is it in the immediate social environment that is likely to influence individual behaviors, beliefs, skills, etc. Peer pressure, social, cultural factors, that sort of thing. At the organizational level, what is it that's going on in schools, worksites, etc. For example, worksite day care policy; for us it would be worksite smoking policy — those sorts of variables. School curriculum, hospital prevention programs, the amount of information that's coming out through various organizations within the community.

At the regulatory community level, things like mass media and social policy enter the picture. These are the factors that we have less control over because alot of the time they originate from beyond the community but tend to affect the community at large and are often of a regulatory nature. For us, this sort of framework really drives a lot of how we do our planning and how we manage to pull together programs. For example, the Eat Right Program that I described. If you look at what it is doing, it is pulling together across levels, because people can work at an individual level or they can work within classes. Whether they go to their physician or pharmacist or to the local hospital, they're getting the same message. That's an important part of what we're doing.

I hear you saying that you have a lot of different programs going on but the message isn't coherent, not all one package. I don't know if that's possible or desirable, but it is a difference between your approach and ours.

(*Pierson*) I think eventually that scheme will be helpful, but I think the main difference is that you've got Heart Disease, two words, an adjective and a noun. Then you can put together your scheme — you know what problem you're working toward. I think the message we were all hearing before is: We don't have an adjective and a noun that we're working on like healthy children. If we did, then we could begin to put together how different strategies can fit into that. Once you've got something that is the general problem, then you've got data bases working toward that and then there are a variety of preventive community-based approaches that can serve that. That's the first step in the goal, having a simple self-evident, obvious need that everyone is willing to work beyond.

(*Chamberlin*) We have the "happy, healthy and nice." Can you think of anything more pertinent?

(*Little*) No pizazz, Bob, it's what everybody agrees with. I use the term "zinger." Where's the zing?

(*Chamberlin*) Anybody have a better idea?

(*Rubino*) I don't know that its important to think about how you market that yet. It's more important to get your framework and your grid and then worry about how you sell that to other people a little later down the line. Because I think what you would find, if you put together an organizational system like this and looking at what you have, you have a lot of the pieces that you need but they don't perceive that they are related to what that organization down the block is doing. Until you have that common perception, you're not going to be able to build that coordinated system towards some shared goal. I would agree that happy, healthy and nice is pretty boring, but for functional purposes it probably is useful in terms of organizing the rest.

(*Jackson*) OK, where does that fit in this kind of scheme? It's a program goal, over in the right column, but what does it really mean to be "healthy, happy and nice"? And at what stage is being more healthy, more happy or nicer important? Do you see what I'm saying?

(*Rubino*) I think that has to be turned into objective, measurable kinds of things.

(*Jackson*) That's right. Like you said, "competence." Does that mean at this point reading is important and that kids need certain skills? That's going to be a positive predictor further down the line for reducing negative outcomes over here. There may be a lot of things, like reading level, that you are targeting, but there could be other things that you're not targeting at this time but that you might be focusing on more at some other stage. I think this is a way to pull it all together. It's potentially a way five or ten years from now to have a single coherent program. I'm not saying stop doing everything and don't do these programs. I'm saying to start thinking about how they all piece together.

11. Should We Use a Positive or Negative Orientation?

(*Chamberlin*) Your model has a negative orientation, in that you're trying to prevent all these bad things. I guess what we're saying is that we want to put it in more positive terms where we're promoting health and social competence, for example. Can you get that into the same framework?

(*Jackson*) You can go either way. It gets confusing when you start mixing positives and negatives but, you're right, we tend to do this from a risk orientation perspective for our planning simply because we seem to get more on the paper when we do it that way!

(*Rubino*) You can think about prevention in those three ways: Preventing some undesirable outcome is where most people start in prevention. You identify something you don't want to happen and, since you don't want it to happen, you do something else. You can then create those other levels of prevention in terms of protecting those behavior that work toward the desirable outcomes you want, and then promoting more adaptive healthier strategies. You need to think about it on those three levels. Where people will enter into the system is different. For example, people would agree that babies shouldn't die before they're one year of age. It's fairly easy to organize people around that. That's a different message than that babies should have better Apgar scores and have less illness, which are other ways of thinking about that. You start where people are in terms of their being able to understand it even though you may conceptualize it on multiple levels: preventing something undesirable from happening, protecting something that's adaptive in the system, and then promoting a more desirable or adaptive behavior. I think you don't have to have it all focused on the negative of what you don't want.

(*Jackson*) I'm not talking about a negative orientation beyond internal planning. In planning, we talk about preventing high blood cholesterol and high blood pressure, etc. But, when we go out in the community we talk about "lighten up," "race to health," coming alive, etc., moving away from those things.

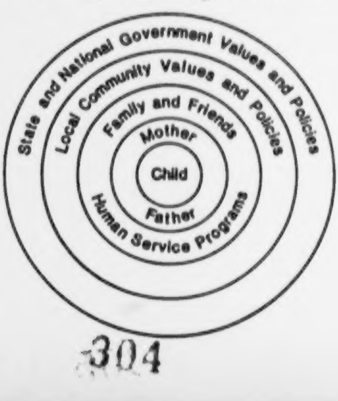
(*Chamberlin*) I would put in the middle section here things like health habits before, during, and between pregnancies that you could do something about in order to get better birthweight babies. At a later stage, I would see parenting skills, in terms of what parents can do when their child gets sick so they don't end up at the hospital, or what parents can do to promote their child's speech and language development. The problem I find is that there are two levels in there. One is the child and the other is the family. That makes it complicated because you really influence the child through the family.

(*Jackson*) One of the reasons to take a needs assessment or negative orientation is that it really forces you to think back another level or two and say what is it that's going on over here that's really driving this; what are the real primary prevention targets. That's why most of our program methods are focused in the community. Those are our fundamental targets, with the hope that these are the secondary targets.

(*Weil*) In terms of language, I think "healthy children," just the two word thing, or maybe "healthy and happy families," for talking purposes at least in the planning stages. I wouldn't want us to just focus on children. Whether we think "healthy, happy and nice" is zingy or not, for talking purposes at least the "healthy and happy" parts of it may be getting at the health and then all the social factors.

(*Jackson*) What you call it really seems unimportant to me. We have a program called "healthy living" where there are like 6,000 people who belong to this program and they get newsletters and they've been hearing about cholesterol screening, etc. But whatever we call it, we're still trying to reduce cardiovascular risk and that's what we see as our goal. I think that's more important than selling that. Selling it is the fun part. That's where you get to think about how people are going to respond to what you are doing.

(*Chamberlin*) This is the way that I think about it.


State and National Government Values and Policies
Local Community Values and Policies
Family and Friends
Mother
Child
Father
Human Service Programs

For outcomes, you want to influence the child. In order to do that you have to deal with the family. If the family is going to function effectively, you have to have support systems. In order for those to function effectively, they have to be supported by community values and community actions. And in order for that to happen, there have to be cultural values and policies that support it on higher levels. How would you mesh that with your model?

(*Jackson*) It's the same. If I took our model and stood it on end, it would be the same model. This is simplified — I just lumped everything into "beyond the individual," if you will. You could rotate it out. This is simpler in some ways. It is sufficient in a lot of ways for planning and needs assessment. I think we'd have to talk about it, but it would be interesting to map out a single causal path, but it's not conceptually different.

(*Mitchell*) Where I'm getting lost is in using the analogy to cardiovascular disease as we're talking about reducing family dysfunction. In most instances, we're talking about things that aren't really dysfunctional. If we're talking about encouraging women to take time off when they deliver their babies because they have a heavy workload occupation, I don't see that as dysfunctional behavior. Perhaps 3 or 4 years down the road after some education we would see that.

(*Jackson*) At this point, the primary target is the woman. The behavioral risk factor for that is hard work during the prenatal period, the same way that sedentary living is for heart disease. An important skill at one of these levels might be communicating with your husband. That was an important skill in the Bangladesh example at the preconceptual level.

(*Chamberlin*) Let's take that through as an example, i.e. hard work is what you want to modify during the prenatal period.

(*Jackson*) OK, at the behavioral level. Skills at this level could be communication. Knowledge and beliefs are also important. For example, this sort of culturally driven belief that it's inappropriate, that there's going to be negative consequences if I initiate this sort of communication with my husband.

(*Chamberlin*) Then you move it one step further. In order to modify exposure to hard work you've got to have in place work policies that encourage people to take pre-pregnant leave.

(*Jackson*) Exactly. You could brainstorm here, but the question is which of these are you addressing and how do you prioritize them, and is there a way to make what's going on at the policy level linked — can you draw linkages between worksite polity and women's beliefs, for example, about getting time off? There are skills and abilities to advocate for change in policy.

(*Chamberlin*) What if we did this for each developmental stage and identified the things we wanted to influence and what sort of policies were needed and put it all together to try to get some sort of coherent family policy out of it. Would that be a way to go about it?

(*Jackson*) That's what I would do. The San Diego Health Department was interested in doing a drug and alcohol prevention program. So we went down there and went to all kinds of community leaders, identifying them simply by dividing the community into subsystems: educational, law enforcement, restaurants, etc. and went to the leaders in each of these groups. We started mapping out what they knew was going on, how they saw the problem, etc. When we pulled away, we saw that everything was individually focused and it was predominantly youth focused. There was very little going on at the environmental level. We were able to show them what, from a planning perspective, they could do to fill in the picture. The working assumptions of projects like ours is that you need to have good coverage and get people coming and going. There is something about the comprehensiveness of it that adds to your ability to be effective. Until you manage to move toward being comprehensive in that respect, you are still going to have an uncoordinated set of programs that you may be applying social marketing to. They may be more effective because you are taking into account where people are, and that's what social marketing is, but. . .

12. Involve State Health and Human Service Commissioners

(*Albano*) I'd like not to lose the thought, but I think you've got a powerful group here in terms of representation of a variety of agencies, dollars, etc., and I think you have to go back to what Dr. Zigler said when he talked to politicians. He goes to the left and presents it one way, then he goes to the right and presents it in another way depending on where they are, but all the time he has a focus on exactly what he wants. My recommendation would be for this group to sign a letter and send it back to the Commissioners of Health in each one of the states, saying that we want to have a demonstration project in each state to do something which I think needs to be fleshed out (and I think that will happen during the rest of this day or shortly thereafter), but let each Commissioner know that they have control over their resources and can pull together things like family planning, child development, prenatal, school health, child health, WIC, Head Start, day care service, services for the elderly, etc. and say that we would like to see in a selected community in each state a comprehensive approach to prevention just like we've been talking about. If N. H. says they are going to do it, Vermont and Maine aren't going to want to see just N. H. do it.

(*Chamberlin*) You are one step ahead. We're still trying to figure out what it is we want to do.

(*Albano*) I'm suggesting here that you get support from the Commissioners because they are the ones who will control the money, and with it control the direction.

(*Chamberlin*) But you can't get the support of the Commissioners unless we're all speaking with one voice. I think that's been the problem. Everybody comes in with their own agenda. Let's get some reactions.

13. The Integrating Concept is the Family

(*Weiss*) I think an issue here is the relationship between the child and the family. The integrating concept in this is family. The way a lot of these things have been pursued is in terms of children and its rare that the family becomes the upper level buzz word. What you ought to do is build on that: have the family as the integrating concept and not simply a scattered set of services for kids, that presumably families access, and that impacts on families. Somehow work with the notion of the family as your buzz word. That gives purchase: it looks different because it's a different way of doing business, a different way of conceptualizing the system, and not always, particularly for young kids, focusing on the individual, but focusing on the context — and that's what an ecological perspective gives you: that access to context, to the way aspects of context influence development. Clearly, for the age group we're talking about, the under 6's, even through 12's, families are key in this. Somehow having that be a central thrust, an integrator, seems to me critical, and that might be something Commissioners will buy into — healthy families, not just healthy kids.

(*Albano*) And that's where you bring in all your resources, from the ones I mentioned plus probably another 20, using that as a core.

(*Weiss*) Yes, you start rethinking your system in terms of that as a focus.

14. How Can We Sell Strengthening Families?

(*Albano*) But to sell it — from the other side, you say you're going to keep more kids in school which has a financial benefit; you're going to reduce infant mortality — use all of the ones we've used all these years to support this.

(*Weiss*) You can get yourself in trouble quickly, but you can sell it to the Right in terms of strengthening families. We've been looking at Maryland. The Maryland initiative is a family resource movement for teen parents which they're trying to broaden out and they've been able to sell it to the Right. We've got quotes from legislators we've interviewed saying this is going to get them behind the traditional families. Strengthening families allows me to do something for families. The Minnesota initiative does not allow day care through that program. That's how they brought along a lot of northern Minnesota rural legislators — because it was going to support the traditional family: moms and kids had to be there together. This was not going to be day care supporting those bad working women. So, I think you have to be careful or you will find yourself in some traps when you try to appeal to the Right but there are ways: the Reagan administration has been producing all kinds of documents about strengthening families, so we can enter debates about what's a strong family. For them, it's not the working mother, but there may be ways around that that would carve a piece of this that some conservative N.H. people and some liberal N.H. people could get behind. It's a risk, but it's possible to get the rhetoric and the goals lined up in a way that they can see something for them as well as some of the rest of us seeing things that would benefit us.

(*Albano*) Strengthening families is as catchy a phrase as you can get at this point. I don't see why you can't use Christine's model here.

(*Jackson*) It would change it because the most detailed approach in ours is at the individual level. What you're saying is that there is also a tremendous amount of detail at the family level. So, you make it a four-stage model, sort of a blend between what Bob had drawn and this one, where you really have family, then individuals, then beyond that the broader contextual variables, like policy and school policy, etc.

(*Chamberlin*) So, you put family next to individual here in the center, is that it?

(*Jackson*) Yes, and I think that would be really interesting to do.

15. How Do We Define Healthy Families?

(*Mitchell*) If we were talking about functional families, what you would look for as your risk factors are the characteristics of dysfunctional families. And what's nice about that is that we then don't get into issues like divorce too much, we don't get into working parents. You look at the basic characteristics of dysfunctional families, where they have low educational levels, particularly parents living in poverty where they don't have job skills. They have chronic either mental or physical illnesses, chronic problems with abuse and lack of connection to the wider community — that is, they don't use social services and they don't have friends.

(*Chamberlin*) But then you get into the deficit model.

(*Mitchell*) Yes, but I think then if we know what those things are then we could say the flip side, that is, what we think are the characteristics of a functional family: they have high educational levels, that is, everybody has finished high school.

(*Chamberlin*) But that isn't true. If you look at the Giovani and Billingsley study, there are some very low educated, low income families that are very functional, that have tremendous coping capacity.

(*Mitchell*) It seems to me that it could be a positive goal, at least from the information that Don was giving us that kids ability to do well has a lot to do with the mom's educational level, so that we could focus on providing education for parents as well as kids. One of the problems, if you are just focusing on child programs, is that you don't get to address what parents need, but if the parents are healthy then the kids tend to be healthier.

(*Weiss*) I would get down to lists of more behavioral kinds of things that are more changeable in the short term as well as the longer term, things like specific kinds of parent-child interaction. This would get it to another level beyond the social status kinds of variables, to certain kinds of things you are trying to change in the way a parent relates to a child, trying to provide opportunities for bonding such as through parent leave, for example. David Hamburg has testimony that he gave before the House Select Committee a month or two ago where he tries to spell out what are the components of a healthy child development. It's a very family oriented thing, where he talks about how one could link in these kinds of things. It has implications at the policy level, it has implications at a variety of levels, but he starts from a basis of "What does it take for a healthy child development?" Well, it takes a family with a set of characteristics, a set of behaviors which are not so hard to change like mothers' education at least in the short term.

(*Mitchell*) I mean educational involvement not level in the sense that you as a parent can continue to learn. . .

(*Weiss*) He builds on that, but a lot of these programs promote adult development as well as child development in the context of a parenting program.

(*Chamberlin*) What else would you put on this for goals?

(*Weiss*) A nurturing parent, which presumes that the parent has social support for him/herself. Respite, relief, reinforcement as a parent, a set of things that allows that parent to be a nurturing parent, then engages in nurturing kinds of parent-child interactions. It gives specifics in terms of certain kinds of language development. Some of the kinds of things BEEP did, it nests: the child needs the parent, the parent needs this set of information and support in order to be able to engage in the interactions with the child, and you can use that nesting sequence to build out.

(*Mitchell*) I would also include some of the SES indicators, to the extent that you can get people involved in changing their own social status, which has a remarkable effect on the kids. If the parent learns to drive, if the parent learns vocational skills, if the parent adopts good health practices and good nutrition for themselves, it is more likely to carry through with the kids.

(*Chamberlin*) Would you put adequate housing in here?

(*Mitchell*) I'd put adequate housing in there, access to transportation, adequate income.

(*Jackson*) We tend to put non-modifiable risk factors into the picture because you want the picture as comprehensive as possible. Then you say, these are all the things we're addressing but maybe the reason we're not having as much impact as we wanted is because we haven't addressed these really tough variables. There are some things you can't change, like age, ethnicity, etc. But it's important to put them into the equation because you have to factor out the amount of effect due to age, family history, etc.

(*Weiss*) Your mediators, in terms of changes in parents, are better problem solving skills, increased self esteem, better coping — these are mediators in terms of adult development that lead to behavior changes in terms of parenting behavior. We need to get those in the causal model. I think Ed's point yesterday was a very important one. As we look at a lot of the programs that have been directed toward improving parenting, they typically measure the child outcomes, so we don't have a lot of clues about what are the causal mechanisms, the mediating variables, etc. that are bringing about these changes.

(*Jackson*) That's true. There was a book that went around yesterday, and all the references on the children were from peer-review journals. All the references on the adult were from books.

It was incredible. That's because it was not research based.

(*Little*) We tend to look toward outcome descriptors in the child population. We don't look for quantitative outcome descriptors in the parenting concept, and yet continue to come back again and again and again to the value of parenting, but we can't describe it as well.

(*Weiss*) But if you start pressing on some of the childhood indicators, people like Jack Shonkoff find that it gets soft and squishy, too, and that some of its predictive value is questionable also. Psychometrically strong child measures certainly will be out beyond the child ecological system but even some of the child ones we've been relying on for different populations turn out to be not so good. I think you can get bogged down in measurement. I think there is some conceptual clarity that's necessary and then there's going to be a lot of psychometric work that needs to be done to measure parenting. But part of that is that there's a lot of questions about values that have to get resolved in terms of what are the parameters of good parenting.

(*Chamberlin*) Where would health habits during pregnancy come in this? Would that be a family goal or an individual goal?

(*Jackson*) That would probably be an individual goal.

(*Mitchell*) I think that's clearly. . . I mean with the first child thats true, but both adequate health care and positive health habits I think are family goals.

(*Weiss*) It depends upon what motivation you are trying to hook into. One of the things that strikes me in a lot of the programs I look at is that the initial motivation was to do something better for my child. Then they begin to realize they get benefits for themselves which then becomes a motivator as well. But I think even with positive health habits during a first pregnancy (at least when I think about my own health habits), it was for my child. Sure, I didn't want my teeth to fall out, but at the same time I wanted a healthy child. Part of it is making the choice that's based on motivation, i.e. what's going to motivate the thing. I think grouping it under the family motivationally makes sense because you know you would be doing this for your child. It's one of the reasons I would put it under the family with the first child.

(*Chamberlin*) But this is kind of a mixture. If you had problem solving ability, that would be an individual thing; if you are a nurturing parent, that would be an individual thing; education would be an individual thing and adequate housing, income, and transportation would all be at the family level. I get confused; it's all mixed together and I don't know how to deal with that.

(*Jackson*) The model really is just to help you structure these — it's not real. It's more so you have an organized framework than it is a picture of reality.

(*Chamberlin*) Maybe you could put these together side by side and have some of the individual things here and the family as a unit here all under family goals?

(*Jackson*) As you start to sort them, slot them into your first impression of where you think they ought to go. Then you say, how would I measure that? It may be that it is truly a family dynamic or it may be that it is an individual behavior or individual skill, so you'd slot it there.

(*Chamberlin*) Then the measures: it seems like you would have direct measures of family strengths in terms of do they have parenting skills, do they have good health habits, do they have adequate housing. The indirect measures then become the child outcomes. That review I did at the beginning shows that all these child outcomes are related to family functioning. It seems to me that you would have that kind of model, then, both indirect and direct indicators of what you are accomplishing. Do you buy that?

(*Jackson*) Primary, secondary. Sure.

(*Weiss*) Also, short and long term. I would also have a time element in this.

(*Chamberlin*) In a way, that's kind of a two-edged sword. If you are using child outcomes to measure adequacy of parents, you can get into a blaming the victim model. We used to blame parents if they had a fussy baby figuring it was poor parenting. Then we found out that some babies are a lot fussier than others and it doesn't matter what kind of parenting you do, you'll have trouble with that kind of baby. It seems to me that you run the risk of this. If you make a big deal out of low birthweight being related to family functioning, there's a certain segment of the population where it is not related to family functioning but to biology, and you're going to decrease the functioning of those mothers because they feel guilty about their doing something wrong. It's this kind of balance that we're always dealing with when you're trying to get at this. We've been through that with bonding. You set up policies to increase the opportunity for bonding, but if parents didn't get the opportunity because of some complication they feel they may have damaged their child for life. Where do we go from here? What's the feeling about whether the basic goal ought to be family or child?

(*Berry and Mitchell*) Two for family.

(*Jackson*) I think it's essential to what you are doing.

16. Putting It All Together

(*Little*) I would suggest that this is the underlying concept, that we've bought into families instead of children, OK? I would suggest from there, because I tend to be a pragmatist and an activist, that there be a 3-state initiative related to this concept. This would include a yearly meeting, development of a coordinating council, and that there be some kind of government, academic, private collaboration on resources. Then you can flesh all those out and try to structure out a 3-state initiative. Then with that 3-state initiative have a fundamental goal of integrating resources around this concept of healthy families. That's the goal. I think that's where Bob's thing comes in, in that long sentence you had. The concept of an integrated support system within communities: community-wide, non-deficit oriented, support — all those things that you mentioned that are things beyond apple pie and motherhood and Chevrolets. Things that we all sense and feel and that you expressed very well. The difficulty with it is that it doesn't have the quick practical marketing zinger that you can hang your hat on. You've taken something beyond the intuitive sense into the expressed sense but it isn't quite there yet in the application sense. I would go beyond this . . . This is the concept and this is the goal. Beyond that, I would bring this down to a bunch of objectives. This is where you and I might disagree, but I feel basically that you've got to have some targets and objectives in order to work within the political resource allocation and other systems. A quick and dirty list of them that I would toss out are things that can be worked with such as Charlie's six-year plan.

Number one, I'd suggest that there be demonstration projects, one in each state, of the support system, a real demonstration project, to get at this goal. That there be an initiative in pre-conceptual care. That's the current thing that I'm onto because pre-conceptual care to me implies families knowing what they're doing before engaging in the reproductive act or at least if they don't know what they're doing they recognize they don't know what they're doing and take some kind of precaution so they don't get certain outcomes from the reproductive act that they don't want to have, i.e. baby. That we look at the issue of prematurity reduction, because its there and its real and its a social problem. That we look at issues of child abuse and neglect. It's a serious social problem driving a lot of what's going on. It's overt evidence of non-healthy families and creates non-healthy family environments. Then we go with adolescent medicine, or let's just say adolescent care. This is a quick and dirty attempt to cover alot of ground very fast. What it gets at is the concept, and this is pretty close to a ringer, and a lot of people can buy into this. It fits into the Right, the Left, and everything else. We're looking at the practical problem of resources, etc. in the 3-state area. It gets us down to a goal which I think integrates with what Bob's talking about, and I've learned alot today about what Bob's trying to teach us all and the reason why he has us here. That, I think, is a goal and goals are something that leaders and organizers and administrators can have without necessarily the need to have everybody recognize exactly what it is when they buy into it. Then there's got to be a place where you get those on the ground and running, like the Stanford program is doing with healthy hearts. You can argue about whether these are deficit related or not, but in a way I think this gets around that dilemma about deficit vs. non-deficit, total vs. risk identification, etc. because what you do is buy into the comprehensive continuity community concept here but you recognize that in order to get something off and running on the ground you've got to deal with certain risk factors, deficits, initiatives, targets, etc. Anyway, I'll toss that out for conversation.

(*Weil*) I had a diagram, too, but I think I'll add some of mine to this one. In this 3-state initiative, I had each state outlined, with what you're calling a demonstration project, a community-based primary prevention project or add-on to what they're already doing, that is locally or state designed. So, in Maine it would probably get designed through our interdepartmental system somehow. It might only be applied in a couple of places. In other places, it may get defined in a local community. The things I had related to them are training and technical assistance and consultation to the 3 states, in social marketing, public education, etc. Planning should probably be listed first, planning and ongoing help with process types of planning, and research and evaluation. Our demonstration projects in our states may not all be focusing on all of these. In Maine, for instance, within our coordination system, we may really want to focus on child abuse and neglect because that's not something we've looked at as well as we would like. We might really like to focus in on some of the prenatal issues within those projects because we're not doing as well there as we are with child health services.

(*Chamberlin*) I would argue that those are all connected and if you look at one you might as well look at the other because they're related to the same thing.

(*Little*) The fact remains you have to apply the Sutton law. You've got to find the resources someplace and whether you like it or not you're probably going to find the resources on a categorical basis.

(*Chamberlin*) I think if you do it from a categorical basis, you need to do it in such a way that you set up a basic system that eventually can deal with the family as a whole.

(*Weil*) The other thing I had in mind is a feedback mechanism for the 3 states, through the various people and organizations we might have consulting to us through an advisory board, so we're feeding information back to decision makers of various types — state government people, legislators, federal people — so that we're giving them a lot of information about what is coming out of this and reasons to work on policies that relate to funding, etc. of these kinds of efforts. So there's not only a social marketing feedback to the families we want to strengthen but feedback to the decision makers who are going to want us to keep on doing that. The other thing we need to do, particularly at the federal level, is to make a case for ourselves, our 3 states, as models for other low population, rural, big geography states, where we've got a lot to teach and learn from.

(*Chamberlin*) One of the big strengths of our 3 states is, as was pointed out earlier, that you don't have to start with the most difficult population first. You start where there are some positives going. You don't have to start in the inner city ghetto where there are so many negatives. We have a very homogeneous population, without big minority groups and no large cities, yet we're still way behind Scandinavian countries in various outcome measures. It would be a lot easier to bring us up to their level than inner-city Boston.

(*Weil*) What I'm saying is what we might learn out of this would have alot of applicability for states like North and South Dakota, Idaho and Montana. Maybe not Massachusetts and New York, but there are other states in the United States that have characteristics similar to ours.

(*Chamberlin*) We have to sell that because every time we apply for grants,they always tell us we don't have a big enough minority population to get funded.

17. View from Washington

(*Kessel*) I think that is a problem. The reality is that when you trichotomize the world some things would change with no resources and some things won't change with an infinite amount of resources. The middle is really where we're more effective. The federal policy, however, is directed toward the population entity which may be the most difficult to do. I don't have a good answer, Bob. I mean, there's the floor and the ceiling. Do you raise the ceiling or do you raise the floor? But I do think there is some opportunity within all of that. One approach to research is to do it under the ideal circumstances first to prove that it can be done. I'm not a hundred percent sure that you want to go that far. I think some of the notions about the characteristics of this community are worth exploring so that it is transportable to other similar settings. I think there's some real value to that.

(*Chamberlin*) I would argue that shifting the focus to families is something that every state needs to do. For example, in Ohio, they are beginning to look at families as a whole and are beginning to make that shift. So it's not that what we're dealing with here doesn't apply to all these other states. It's just alot harder for many of them because there is a lot more mix.

(*Kessel*) I started out negative but from our perspective what you are trying to do has some real positives. I think the fact that you talk about strengthening families gets you 30 points. The fact that you talk about a regional component, gets you another 30 points. The fact that you're talking about integrating resources and trying to wrestle with an economy of scale, you get another 30 points. I think that there will be a lot of potential as you mature and develop it. I would add one other thing that you may be considering that isn't as obvious as I sit and listen, and that is the private sector component that exists in this region. I mean you characterized it yesterday and I was going to ask about how does "Live Free or Die" relate to all the things that you want to do. That's part of that challenge. Someone talked about making a community inventory, and I think the cultural attitudes and beliefs need to be taken into account here to some extent. You could put all the resources you want into it, but if people really don't want to use them, all other things being equal, then it just isn't going to work. The other buzz word, besides "private sector," is "sustainability." Some notion of once this catalyzing energy is brought together that it has at least some potential for sustaining itself. Because the benefits, whether they be in terms of human capital or real capital, are at least identified. To some extent, you are re-inventing, from the conceptual perspective, the block grants. Put them all together, local people will have some autonomy to pick and choose and integrate and develop their priorities, and even to some extent some notion of once we do all that it should cost us less. I think from a conceptual framework that the block grant was not an erroneous notion. Strategically, it might have been done differently, to wait until the reward for the efficiency was there to be re-invested, so to speak, rather than cutting at the outset, but that's a strategy. But I think with those two additional components. . .

(*Weil*) I think they're in there, in my scheme of things. Those state initiatives would be embedded in what is currently there and what is, in many cases, firmly there with state funds. So that, in my mind, these demonstration projects would not be totally a new thing. Maybe to one or two of the three states it would be new but, in our case, I would like it to be taking the system we've got and adding to it the things we know will make it a better system. In our situation it is something that's in the infrastructure, funded, and a line item in the state budget already. So, it's got that sustainability.

(*Chamberlin*) Certainly, Cheryl's eight-community model would be a nice one to add on to.

18. Private Foundation Perspectives

(*Weiss*) I think I know more the private foundation side of things than I do the public side. It seems to me, as I watch shifts in places like Carnegie and Ford and Rockefeller, that they are in the post-pilot phase of things, and I say that with a specific example in mind to illustrate what I mean. Some of you may know Project Care, also known as the Abicidarian Project in its earlier life, but Craig Ramey and Donna Bryant have done it in North Carolina. They demonstrated some very important things. If you ask Donna what they are doing now, she says what she is doing is working with a local public health department in North Carolina to figure out a model that they can actually afford to implement on a more widespread basis, because the whole Project Care program costs more than what can be absorbed in the state system. It seems to me, as I look at some of the thinking that's going on in the foundations, that they are moving into the post-demonstration research era. If you look at what demonstration research projects have been replicated — very, very few. And when they are replicated it's one or two sites. People are now beginning to realize you need to work with states to build the kind of infrastructure to achieve the very things you were describing. The best possible model demonstrates that you can achieve some things, but if nobody ever does anything with it, what good is it?

(*Kessel*) I would agree with you. In fact, we had this year for the first time something called incentive grants. . . circumscribed in the sense that if you had received lots of money before you couldn't apply, but it was really to apply the knowledge that had been developed, tested and, if you will, demonstrated. There's another initiative in the South on infant mortality (the Johnson Foundation) that is to apply what we know. The hard part is keeping the rhetoric tracked consistently, just as you struggled through the issue of objectives, and it synthesized very nicely I think, micro, macro strategies to reach those objectives, sometimes the strategy itself became the objective. One needs to track those kinds of issues. One of the issues, that George challenged us with to some extent, is what is parenting. Well, if you raise that as an issue, that sounds like a research project. If it's talking about integrating services to serve more people better, that sounds like a post-demonstration project. Somewhere in the middle of all of it, it has to be tracked. If you put yourself in the reviewer's place and start out with an idea, you don't want to end up someplace else and be a little confused that they're trying to do good things for all people because it gets a little muddy as you wander through it. What I think is really terrific here is your bringing together this litany of wonderful presenters that you have from Head Start, to behavioral categorical intervention, to preterm delivery, to an educational kind of thing, and trying to integrate that through the family. But some people would argue that the vehicle, the family, is still an uncharted domain. The integration of services is not. But that's an issue.

(*Weiss*) That's why we should ask someone like Don to speak. It seems to me that we have 20 years of interventions, even the Perry Preschool Project which worked with families through a once a week home visit. We could relabel them as family interventions because they made a set of judgments about what was proper parenting behavior, and what were the skills and information and supports that parents needed. So, I would argue that we have twenty years of experience on which we could build. We called those child programs, but a hefty subset of them were family programs. Some of them even have a few family outcome measures such as changed parent-child interactions. We can draw on that legacy. That legacy involves some of the kinds of things that we have listed today, such as service integration, comprehensiveness, and a set of information and skills that we think parents need. We haven't thought of it in that way because we've been so oriented toward children, but we really do have more expertise and more on the ground and research experience, and evidence in this arena, than I think we sometimes realize. I think you should speak to that from your perspective in BEEP.

(*Pierson*) There's no question as far as family orientation being the crux, and even in the study that Ed didn't like, Bronfoenbrenner's study in 1974-75, which criticized the majority of Head Start programs, the thrust of it was, as I understand it, that the only programs that have lasting benefits are those that have strong parent involvement components. The part that I'm still a little confused about is how to deal with the changing nature of families. Maybe when we're talking to the conservatives it's okay to talk about strengthening families, but the reality of when you're talking about adolescent mothers, etc. is really what is the family?

(*Weil*) I feel that we've got to acknowledge and admit that that's real varied. I mean, a single adolescent mother and an infant is still a family. She may have lived with grandparents and she may live on her own. A family constellation is not what it used to be and that's part of what makes the strategies more complicated and the objectives more complicated. But I don't have a problem with defining the family in that broad complicated way that it currently is.

(*Rubino*) I don't think the point of what you're trying to do is define what an ideal family ought to look like but what roles the family plays in the development of the members in it in terms of adaptive skills. I think that's what you're looking at. I think the charts have been additive and richer with every successive addition to it. I think you need to separate out what some of your family outcomes are from your process or service delivery outcomes, and there's a little intermixing there, so that you don't mix up what you want to happen in terms of, say, coordination of service, and then measures of why that's important in terms of family outcome or program outcomes. I think you need to do a little sorting in your charts.

(*Weil*) I wanted to go back to one other point that I think strengthens what we're talking about, around replication. I think it is true that nationally a lot of the expensive demonstration projects that have been funded have not been widely replicated. However, Maine is an example of having replicated 3 pilot sites into the statewide system with state money, and Vermont has taken a couple of demonstration sites and replicated into 8. So I think we need to pull on that and recognize the fact that states with state funding have taken some good things that have gone on in their states and replicated them.

(*Weiss*) I think in the recent four states that we studied that is exactly the same way every single one of them proceeded. The difference is that they are not fancy, what I call flagship research and demonstration programs. They were about getting a thing in place, getting it going, maybe there was a little evaluation component, but none of the four states had what I would regard as a sophisticated research design that puts them into the research demonstration category rather than just the service demonstration category.

(*Weil*) And that's where having some research built into this would really be very helpful. But I think from the foundation perspective, that kind of bootstrap and doing what you can with what you've got, is what we've got some demonstrated capacity for having done — with Yankee ingenuity or however you want to market that.

(*Chamberlin*) Susan, do you want to respond to this from a foundation director's standpoint? What do you see that would be helpful?

(*Susan Bunting*) I was just thinking, very much from a practitioners point of view, on exactly what can be sold to foundation trustees. I go in and out of being overwhelmed as I sit here trying to put this in a practical perspective.

(*Chamberlin*) Do you want to tell us who you are?

(*Bunting*) My name's Susan Bunting and I've been invited to observe. This has been a fascinating opportunity for me and I was expressing that I wish there were more people sitting around here having the opportunity to be active listeners. I'm the Director of the Foundation for Seacoast Health which is a private foundation in the seacoast area, which constitutes nine communities, three in Maine and six in New Hampshire. Basically, our Foundation is very young. It's two years young in that our hospital was in a state of demise in Portsmouth, N.H., so it was sold to the Hospital Corporation of America. The funds from that sale plus all the original endowments that the hospital enjoyed went into a private foundation. Now what we do is give back through grantmaking in the nine communities approximately a million dollars a year, that's in a population of about 60,000 people. So that's a significant amount of money in a small area. Subsequently, we have become a very grassroots foundation in that the RFPs have been developed by community people and these are people who have had to put aside turf issues and to look at a much larger broad base of funding and program development as opposed to their programs being the goals. For many people who are service providers, their programs become their goals. They are learning now to see the forest for the trees in this whole process. So, the RFPs that have been developed are very much on a design such as this except that we don't have that kind of language. So as I listen to you I think "Gee, I don't have the proper language to present this back to my trustees," and yet, if I utilized your language, they probably wouldn't listen to me because they are not used to it. Consequently, I'm busily translating what you're saying in a language that I think they will listen to as far as it is a preventive program.

I was sharing with Dr. Chamberlin that we just funded a very expensive program, with our very lofty goal developed by the community as developing adolescent self esteem. Then we backtracked. We don't have to do a needs assessment because we have already indicators in place, such as the school dropout rate and the teen pregnancy rate. We have a prenatal clinic that we're supporting together with maternal and child health at the state level, and we've expanded that into the school. We can't call it a school-based clinic, it probably will never be called a school-based clinic, it's not even a school health program. It's just that we have components. We know where we're going, we just don't talk about the goal. We just quietly place in certain characters until we have our whole play. But in our lofty goal, we backed up to what do we have in the seacoast area that now is lending itself toward developing adolescent self esteem? What exists? What doesn't exist? What is needed, depending upon the indicators? We have a tremendous school dropout rate. What is happening to those kids after they drop out? So, we used community resources, people that exist to get that information for us. Now we're developing programs, which is pretty much at the objective stage, very measurable objectives as to what doesn't exist and what do we need. Everyplace we can we attach it, to whatever exists, because it's more cost effective. We don't have to have new administration. So, many of our programs that we're funding are school based. Almost all of them are for adolescents, except for a teen center that we've developed. Hopefully, it will be a very comprehensive teen center at some point, much more than just a hangout place for kids. There are all sorts of Outward Bound activities going on at that center. It's designed specifically for a deficit model. The first time I every heard that term was when I came here; it was basically for at-risk kids. The trustees are having a really hard time listening to the reports because in their minds this is for at-risk kids and therefore only at-risk kids should benefit from this center when, in fact, the center is attracting all kinds of kids, which is exactly what we want. Now somehow I have to have Dr. Chamberlin come and speak to them and convince them that you can't just deal with those kids at-risk. Probably the saddest but best example is a 14-year old that committed suicide about three weeks ago at your high school. No one had a clue that this youngster had a problem, not a clue. Guidance didn't have a clue, teachers didn't have a clue; it was a really dysfunctional family but no one knew. Those are the kinds of situations that are real, people listen to, people see in the newspaper, and we have to do something about. In a comprehensive manner, we've done just as you've said: we're breaking it down into pieces because people can understand pieces. . . .

The rest of the discussion centered on how to follow up this conference. Issues identified were:

1. How to build a broadbased constituency of persons in each state oriented toward promoting healthy families.
2. The timing of how and when to seek financial support and/or technical assistance from local and national foundations.
3. The need to keep working on an overall framework based on the Stanford model and to establish a common database. (See Epilogue for continued progress on these goals that occurred in follow-up meetings in January and April of 1988.)
4. Identifying ourselves as: The Northern New England Coalition to Promote Healthy Families.

SUMMING UP

Following is my attempt to sum up what we have learned about implementing community wide approaches to primary prevention from conference participants and related reading. I will discuss this by trying to answer the following questions: (1) When does it make sense to implement a community wide approach to promote the health and development of all families and children rather than concentrating resources on some particular high risk group? (2) What are the basic design elements essential for a community wide approach to promoting healthy families? (3) What have we learned about implementing primary prevention programs at the state and local levels and through public/private cooperation and with the use of social marketing? (4) What do we need to consider in evaluating community wide approaches to promoting healthy families and children?

1. Indications for a Community Wide Approach

The basic conditions indicating a need for a community wide approach to health promotion are: (1) that risk factors for negative outcomes are widespread through all levels of the community; (2) risk scores follow a more or less bell shaped distribution curve with the bulk of the population falling within a medium risk range; (3) there is at least a modest linear relationship between risk scores and a variety of negative health and developmental outcomes but the predictive validity for individuals is not high; (4) risk status is a dynamic state between environmental and biologic factors that changes over time.

Under these circumstances it is unlikely that an approach concentrating only on the small number of people at the high risk end of the distribution will have any long term effect on the incidence of related problems for the community as a whole because there are so many middle risk persons ready to take their place as their life circumstances change. The successful results of the Stanford Heart Disease Prevention Program in this country, the Preterm Delivery Prevention Program in France, and the child and family health and support programs in the Scandinavian countries are all cases in point. Each has concentrated their preventive efforts on the population as a whole, and on changing the environmental context as well as changing individual behavior. All these programs work by preventing low and middle risk persons from becoming high risk.

In the introduction to the conference, it was noted that risk factors for family dysfunction such as being an isolated single parent and/or a working mother without adequate child care or being under a heavy stress load for any number of reasons are widespread throughout our communities. We also saw from a review of the literature that, as risk factors pile up, the probability of an adverse health or developmental outcome for a child increases. If one translates family dysfunction into the health habits of women in the reproductive age period related to pregnancy outcome and the parenting skills of both parents that promote the health and development of the child after he or she is born, it is possible to develop programs to influence these behaviors and skills in positive ways. However, it was also noted in the introduction that these birthing and parenting behaviors are in turn related to how well a parent is coping with his or her balance between stress and support at any one point in time so that preventive/promotive programs will have to address the environmental context as well as the parent and child. As might be expected from this mix, longitudinal studies have shown that we cannot predict accurately into the future which families or children will be affected and to what extent. Thus, it appears that all the conditions are present to indicate that a community wide approach will be necessary if we are to have a significant impact on preventing the many types of child health and developmental problems that are related to family functioning.

2. Basic Design Elements

A number of important design elements were identified as necessary to reach the overall goal of promoting healthy families and children. These include:

A. A defined geographic area large enough in size to provide an adequate population base for efficient services, yet small enough to maintain a sense of community and local control. Not enough attention was devoted to this rather basic component of program design. One of the first things the Scandinavian countries did in improving their system was to aggregate administratively small communities into larger municipalities or districts to make program delivery more efficient. For primary health care this came out to a population base of around ten to twenty thousand inhabitants, with a range from about six thousand in rural areas to some large cities of sixty to a hundred thousand. Larger cities are broken down into smaller districts of varying size for different levels of service. Maternal and child health centers served an average population base of about five thousand residents and child care centers a base of three thousand persons.

Program catchment areas in the United States have been communities such as small towns, school districts made up of several small towns, cities, counties or portions of counties, and states as a whole. Large cities have been broken up into districts, neighborhoods, wards, census tracts, or school districts. The question of catchment area size was not adequately addressed in this conference, but there was a general consensus that the target area must function like a community in terms of its residents sharing some common goals, and having an established pattern of shopping, employment and political representation.

B. *A data base* that can be used for needs assessment and to monitor program effects over time: It was clear from the state presentations that the data available is scattered over a number of different agencies and organizations. This makes it difficult to put together a data base to form a coherent picture of what is happening to families and children in the State and what the strengths and weaknesses are of the programs that are available to help them. Data by country was the most prevalent, but many counties are too large and/or heterogeneous to be used as an adequate population base for services.

C. *A Non-Deficit Orientation to Service Delivery.* It has been noted by Bronfenbrenner, Weiss and others that in America a family often has to prove to officials that it has been a dismal failure in order to access services. If a program goal is to strengthen families by enhancing parental competence and self esteem, it was generally agreed by the participants that a deficit model is self defeating. The successful programs presented were all open to anyone who wanted to use them and made affordable so that economic considerations were not a major barrier.

D. *Comprehensive Array of Programs.* There was general agreement that the environmental contexts related to family functioning had to be addressed as well as individual behaviors and attitudes and that there is no "magic bullet" program that will cure everything or magic age period that is all important. Rather there must be a variety of programs to provide the environmental nutrients that every family needs to function effectively with children and youth of different stages of development. The basic elements include the following:

(1) Programs that promote self help and peer support: Many of the participants noted that parents cited friendships and support from other parents as one of the most valuable aspects of programs. Examples of these are parent drop in centers and support groups for parents experiencing a wide variety of stresses such

as having a handicapped child, being a single parent, undergoing a divorce, and take care of an incapacitated elderly relative.

(2) Outreach through home visitors: A number of conference participants noted the necessity of using home visitors to reach geographically isolated and/or highly stressed families that are often too energy depleted or lack transportation to make use of center based and/or peer support types of programs. Transportation is a big problem for many families in Maine, New Hampshire, and Vermont.

(3) Quality child care and preschool programs that promote social, emotional, and cognitive development as well as provide a healthy and safe environment for the young child.

(4) After school child care and recreation programs for older children.

(5) Programs based on a philosophy of wellness to promote general, prenatal and child health.

(6) Adequate health insurance and access to high quality primary and specialist health care.

(7) Flexible work schedules, and paid pregnancy and child care leave. Work site and school site child care and parenting programs.

(8) Public transportation, affordable housing in safe neighborhoods, and programs to promote community cohesiveness.

E. *An Overall Framework to Coordinate Programs*: Coordination of programs is essential. It was thought important to develop an overall framework to guide program development. The use of the 3 stage model developed by the Stanford group relating (1) status indicators of desired outcomes, to (2) the behavior, attitudes, knowledge and skills of the target population, which are in turn related to (3) the social contexts that influence them (family, peers, organizations, the mass media and community values and policies) was found to be quite useful. However, in our setting it was found necessary to use family as well as child outcome indicators with the latter changing with each developmental stage (prenatal/neonatal, under one, one through four, five through twelve, and thirteen through nineteen). While there are common parenting issues that underlie them all, there are also significant differences that relate to each stage.

F. *Building a Broad Based Constituency and Public/Private Collaboration*: There was a general consensus that a mix of public and private initiatives was the best way to tap local energy sources, coordinate resources, and avoid creating total dependence on a sluggish and sometimes unresponsive bureaucracy. This principle appears to hold true in the Scandinavian countries as well as in the United States. Building a broad based constituency is necessary to find the best way to design and fit new programs into the existing pattern of services and counter attempts by politicians to cut back programs at the first sign of a budget squeeze.

G. *Other*: Another design element thought to be important was to not pick the hardest place to start a new program. Starting with a medium risk community rather than a high risk one and picking a program relatively easy to implement will improve the chances of initial success. Experience gained from this can be used to tackle the more difficult communities and put into operation more complicated programs.

Concentrating on what can be changed and building on what's already in place were other recommendations based on participant experience.

Pilot projects were seen as useful to work out methods, but as soon as the basic elements are identified one should test the cost effectiveness over a much bigger population base to see if it is economically feasible. All too often pilot projects are designed for Cadillacs when the economy can only afford Volkswagons.

3. Implementation of Programs

A. *At the Local Level*:

The Stanford group has stressed that the community is a dynamic independent system characterized by norms, rules, and established methods of resource allocation. These must be understood to see how best to fit in a new program. Experience indicates that political and economic needs must be considered as well as program needs.

1. *Build a Broad Based Constituency:* The first step is to build a broad based constituency of support and involvement. This is generally done by establishing a community advisory board composed of influential community members who can provide access to important organizations and individuals and managerial level persons who have been successful in program start up and development. This board then defines the geographic catchment area, builds a data base to identify problem areas and gaps in services, sets priorities, and develops specific objectives. Finding money to hire a community coordinator is an important step in facilitating interagency collaboration and program development.

2. *Develop an Overall Framework:* Using the three component model worked out by the Stanford group is a useful way to develop an overall framework for program development and coordination. Using this model one can design "multiple behavioral change strategies," and implement them through "multiple communication channels," targeted to multiple audiences, in multiple settings. It is here where knowledge about and skills in social marketing are vital.

Examples of well functioning coordinated, comprehensive, nondeficit oriented, community wide programs to promote healthy families and children are the Addison County approach in Vermont, The Child Health Center in Norway, Maine, The Brookline Early Education Program in Massachusetts, and the neighborhood based Buddle Lane Family Center in Exeter, England.

3. *Advocate for Necessary Changes at the State Level:* Another role for the local community is to act as an advocate to promote the changes needed at the state level to facilitate local program development. These are discussed in the next section.

B. *At the State Level:*

State government and agencies can greatly facilitate program development at the local level by developing an overall policy statement to guide activities, coordinating efforts through interagency collaboration, and passing legislation to insure stable long term funding.

1. *Promote Interagency Collaboration:* Program development and coordination can be greatly facilitated through the formation of an interagency committee or subcabinet that meets on a regular basis to: (a) identify some common goals and priorities, (b) find money and other resources to facilitate the development of primary prevention programs at the community level, (c) jointly review submitted proposals, (d) build a common data base to monitor what is happening to children and families in the state over time, and (e) develop program standards to insure comprehensiveness and high quality.

The most crucial element here is how to tap into and facilitate local energy. One way to do this is to provide start up money through an RFP process which stimulates local action. The state can build in broad guidelines to insure high quality and comprehensiveness, but the local community retains control over how the program is to be implemented. One problem with this approach is that some of the most needy communities don't apply. Sometimes this can be facilitated by holding a workshop in the area to identify problems and potential leaders and build on that.

Successful examples of interagency collaboration at the state level were presented by the Ounce of Prevention Program in Illinois and the Maine Delegation. In each case an inter-departmental committee or subcabinet was formed to meet on a regular basis and coordinate programs involving some segment of the population such as adolescents in Illinois and children under six with developmental problems in Maine. Collaboration to coordinate programs to promote healthy families and children as a whole was not identified, nor was the pooling of funds to support primary prevention programs. However, in Illinois some coordinated funding of programs for adolescent parents was accomplished. A private non-profit agency in New Hampshire has put together existing data sets to get a more comprehensive look at what is happening to families and children in that state. Vermont has developed a community profile with a number of social and economic indicators for each county, and an example of a somewhat similar data base for Ohio is available from the Children's Defense Fund. For interagency collaboration at the state level the basic advice appears to be to start a pattern of collaboration no matter how small and then build on it.

2. *Develop a Resource Center:* Once a course of action is decided on by the local community, the state can facilitate start up by providing technical assistance in such areas as: training in primary prevention, community development and interagency collaboration, social marketing, provider training, establishing a data base for program monitoring and evaluation, and help with local resource development. A resource center to provide this kind of assistance can be developed either within the state agency system or contracted through an outside organization. An example of the former is the Heart Healthy Program in Vermont. To implement community wide programs to prevent cardiovascular disease the health department established an office of health promotion and hired a director and two health educators to work with local communities. Money from the Prevention Block Grant and from state general funds were used to fund programs in 8 communities with yearly grants of $7,500 to $10,000. The state office helped with planning, development of materials, training local staff, provider education, media campaigns, and program evaluation.

Examples of independently funded resource centers are the Ounce of Prevention Fund in Illinois and the Stanford Center for Research in Disease Prevention. State and local governments and/or agencies can contract for services provided by these organizations.

3. *Establishing Sustained Long Term Funding Through Legislation:* Stable long term funding is essential for program success. This is often difficult if not impossible to do without some underlying legislation to insure program continuity. The previous discussion would seem to indicate that it makes most sense to design a comprehensive, coordinated package of programs and then try to implement it as a whole through legislation. However, the legislative experience of the participants all pointed to the fact that most programs were passed as a response to a single problem that had reached the crisis stage and were targeted only to those considered most at risk; i.e., the tertiary level of prevention. This generally leads to a series of fragmented, deficit oriented programs that do not reach the underlying causes of incidence. Strategies to deal with this reality were discussed.

One way is to design categorical programs in such a way that they can be expanded to a more comprehensive focus in the future. It was generally agreed that it was important to get a basic principle in place no matter how modest the actual program content. Once in place one can build on it with future legislation. An example is the pregnancy leave and child care bill currently before Congress and a number of state legislatures. It proposes 12 weeks of unpaid leave which means that most families will not be able to use it because they can't afford to take that much time off without pay. However, once in place more adequate features can be added on through amendments at a later time. Other ways to add elements before more legislation can be passed are to build in standards to insure comprehensiveness and quality and regulations such as requiring parent participation in decision making to promote local control.

Finally some states have been able to convince the legislature to fund a modest pilot project to test the feasibility and cost effectiveness of a more comprehensive approach. If this can be jointly funded by a private foundation such as happened in Illinois, it will be easier to get supportive legislation passed.

Another fact noted was that the timing of legislation was often more important for passage than having proof of the cost/benefit of a particular program. The same data is often interpreted quite differently as the political climate changes. Examples of legislative readiness were the implementation of a nationwide pre-term birth prevention program in France as a method of reducing handicap in children. At the time of passage, the only data available to indicate such a program would work was a small pilot study done in one hospital. Another example is the statewide parent education and support program in Minnesota. This is based on the Brookline Mass. model and was implemented in Minnesota before there was any data showing benefits because an influential legislator thought it made sense and the time was right. Head Start was started nationwide on a similar slim data base. Once in place, however, cost effectiveness data is important in resisting efforts to cut the program when the political climate shifts against it as was the case for Head Start.

Advocacy: Another important feature of getting programs passed and resisting later attempts to cut funding is to develop a broad base of support. The best combination is to have the same message coming from the community, state agencies, and within the legislature. States such as Vermont, Illinois, and Maine, that have been successful in passing legislation to promote healthy families and children, have developed strong advocacy coalitions in local communities, at the state level, and within the legislature. Agency support often depends on whether or not it's on the governor's agenda. Some ways to put it on the governor's agenda are for the community advocacy groups to write to the governor and build up media coverage, or have the legislature mandate the formation of a task force to study the problem and come up with recommendations. A task force can also be set up by the governor to educate the legislature. Sometimes an influential person that has the governor's ear is all that is needed to get the ball rolling. An example of a legislative effort to establish an overall family policy was provided from California by Heather Weiss. The National Academy of Sciences published their attempt to do this at the national level in 1976 (see reference listed in preface).

The State of Massachusetts has actually institutionalized advocacy by mandating the setting up a citizens group in each local community. In Finland much of the legislation that has been passed is the result of activities of the Mannerheim League for Child Welfare which has organized groups in over 400 communities around the country, and has developed the capacity to educate and gain publicity through social marketing. Others have noted that it is helpful to establish a legislative caucus within the legislature to work with outside groups to get legislation passed.

C. *Public/Private Collaboration:*

Joint private and public funding allows state agencies and local communities to take more risks in starting new programs. Private foundations can put up matching funds or pilot new programs for later adaptation by state agencies. In addition, privately funded programs can help fill in gaps in services provided by public programs.

The Ounce of Prevention program started as a joint effort between a private foundation and a state agency. Each contributed $400,000 dollars to fund six community wide pilot projects across the state that combined home visiting, a parent drop in center, and a day care program. The experience gained from these pilot programs was then available to use when the legislature passed an appropriation for much larger amounts to support the Parents Too Soon Program for teenagers in 37 communities.

The Mannerheim League of Child Welfare in Finland has helped pilot and disseminate parent education programs for state financed maternal and child health centers and an arts curriculum for child care centers. A private Mothers Help organization in Denmark fills in gaps left open by local government funded social services. Private foundations in Sweden have developed an ombudsman role for children and families.

D. *Use of Social Marketing:*

Participants in the conference brought out one point over and over again. To sell primary prevention one must be sophisticated in the use of the mass media. This is necessary to get the attention of the public, educate them about what needs to be done, and create a demand for solutions.

To reach different segments of the population one must do "feed forward" research. This means conducting focus groups around the community to identify different levels of awareness about program need and content, what points of resistance will have to be answered, and what words are important to use in getting concepts across. Several persons made the point that you have to educate persons who have the power to influence the target audience as well as the target audience itself. This was brought out clearly by Manoff in a television spot used in Bangladesh to reach husbands who were the key persons to influence in terms of their wife's use of birth control. Reaching older sisters of pregnant adolescents around the importance of prenatal care was another example as well as reaching adolescent males with messages about birth control.

Message design issues were also discussed. In general messages must be simple, specific, and coordinated with each other so that there is no message dissonance. Messages need to be pretested for comprehensiveness, acceptability, and believability and delivered through multiple channels (radio, TV, newspapers, posters) in multiple sites (businesses, service provider offices, schools, stores) and to multiple target audiences (old, young, educated, less educated, blue collar, white collar, right wing, left wing, minority group, etc.). An overall plan needs to be devised in terms of message sequencing, frequency of and duration of contact for a given message, and target groups. It was also noted to be important to try and get misleading and inaccurate messages corrected by complaining to the media source and getting equal time for rebuttal etc. when these surface during a campaign.

Finally, it was pointed out by Manoff that one should not rely on the mass media to try and solve problems that require structural solutions. An example of this was the use of the media to encourage mothers to breast feed while feeding newborns in the nursery with commercial formula and giving new mothers a free package of it to take home.

4. Program Evaluation

With a community wide approach one obviously cannot randomly assign persons to treatment and control groups so one must rely on quasi experimental designs. Program effects can be monitored by following the course of certain key indicators such as rates of serious physical abuse, low weight births, and hospitalizations of children under one. In addition, periodic surveys can be taken to ascertain such things as: (1) the level of risk factors in the community such as the number of children living in low income and/or single parent families, and the number of women smoking during pregnancy; (2) the degree of message penetration for different target groups; and (3) changes in access to community services.

These rates can then be compared with those in similar communities in the same region and with rates of other conditions in the same community that would not be expected to be affected by the program. The Stanford group has been able to show significant reductions in risk behaviors related to cardiovascular disease in their target community compared to other communities. In Finland, during the time that a nationwide network of maternal and child health centers was being established and infant mortality rates were coming down sharply, deaths in older citizens from heart disease and tuberculosis continued to be among the highest in Europe. Likewise in France when rates of pre-term birth were coming down in that country they remained unchanged in other Western European countries such as Germany and in the United States in spite of similar levels of technology and living standards.

Perhaps the most important message to come out of the conference in regard to evaluation was that it takes time to see the effects of a community wide approach. One cannot expect much in the way of results for one, two, or even three years. For example, it took four to eight years to show results in the prevention of pre-term births, and six or so years to achieve lower infant mortality rates in Finland. One can, however, show changes in risk factor rates such as smoking during pregnancy and changes in use of prenatal care in shorter periods of time so you can at least tell if you are headed in the right direction.

It was also noted that there is a certain amount of redundancy in primary preventive programs. One needs to reach a certain critical mass of program penetration and utilization before effects can be achieved and it is difficult to know just what the optimal level of coverage is.

Besides looking at program effects in terms of changes in rates over time, one can also try to answer internal questions such as which child or family will benefit most from which type of program. For example, in the Brookline program and in the French studies it was found that the less educated and low income families responded more to the home visiting component than the more educated and higher income families.

Another important point that was mentioned many times was the importance in looking at a broad array of outcome measures related to the intervention such as what has happened to the parents, the family as a whole, and the community as well as the children. This lesson was painfully learned with Head Start which was initially termed a failure because one could not demonstrate long term effects on measures of intelligence in children. However, it has since been well documented that these programs had striking long term effects on the health status and school performance of children, on the self confidence, parenting skills, job attainment, and community involvement of parents, and on making communities as a whole more responsive to the needs of families and children. One of the most lasting effects of the Beep program was the placement of several former Beep parents on the Brookline school board to advocate for continued funding and expansion of these types of programs.

5. Progress at the State Level in Maine, New Hampshire, and Vermont:

A. Progress toward promoting healthy families and children at the state level can be monitored by answering the following questions: (1) Is there a written statement articulating overall goals and objectives for a statewide family policy?

(2) Has an overall framework such as the Stanford model been developed to guide program development and implementation?

(3) Is there a comprehensive data base that can be used for needs assessment in different parts of the state and for monitoring progress after program implementation?

(4) Is there a state interagency committee to coordinate programs and seek out resources to fund primary prevention projects?

(5) Is there a non-deficit orientation to program development?

(6) Is there a statewide resource center to assist local communities in establishing community wide approaches to promoting healthy families?

(7) Has legislation been passed to encourage the development of primary prevention programs and provide long term stable funding for quality programs?

(8) Is there a statewide grass-roots advocacy group for children and families to work with legislators to fund primary prevention projects?

(9) Is there a legislative caucus to work toward the passage of bills to support programs for families and children?

(10) Are there some model programs that can be expanded into other parts of the state?

(11) Are there locally or state based foundations that are willing to participate in public/private partnerships?

B. *Applications to Maine, New Hampshire and Vermont:*

Of the three states, *Vermont* appears to be the farthest along: There is a Council of Children and Family Preventive Programs with representatives from all the major agencies dealing with families as well as judges, legislators, providers, and several child and family advocates. This group meets monthly to coordinate activities and has formed task forces to address specific issues such as promoting primary prevention through the Children's Trust Fund, juvenile justice, legislation affecting families, and adolescent pregnancy. A statewide prevention plan has been passed and a regional prevention coordinator has been hired in six of the 12 administrative districts. A system has been worked out to provide a case manager for every pregnant teenager.

In terms of a data base, the planning office has established a social profile of each county to be used as a guide to needs assessment. There is also a strong statewide advocacy group that has worked with the legislature to pass a number of bills. These include training in primary prevention, state money for prenatal care, mandatory kindergartens, and additional money for preschool programs for three and four year olds. The health department has started several pilot projects providing home visitors to first time parents.

A resource center has been developed at the state level to help communities develop primary prevention programs related to cardiovascular disease. This model could be adapted for promoting healthy families at the local level as well.

Finally, there are a number of model programs in the state including outstanding examples of a county wide approach to promoting healthy families in Addison and Lamoille Counties, a town wide approach in Milton, and some good local examples in six other counties.

Maine has established a system of interagency collaboration at the state and county level in regard to services for children who are handicapped, delayed, or "at risk" for developmental disorders. This could be broadened into a primary prevention focus with additional input. Maine has also developed a statewide approach to parent education and has established a number of pilot projects to support teenage parents such as resource centers and school based day care and parenting programs.

There is a statewide advocacy group for children which has been successful in passing legislation to establish a trust fund for child abuse prevention and provide state dollars for expanding Head Start. Improved and increased child care has been a prime objective of the current governor and a substantial appropriation was passed by the legislature.

New Hampshire is still guided by an ideology of government non-involvement in family matters, but is beginning to make some efforts in promoting healthy families. Money to fund primary prevention programs at the local level has been developed by requiring that 5% of the county money spent on placing juveniles out of the home be used for prevention. The Division of Children and Youth has fifty thousand dollars of juvenile justice money to give out each year to local communities for primary prevention projects. These have resulted in the formation of several parent drop in centers and a number of other parent education and support programs. An interdisciplinary committee reviews these proposals. A trust fund has been established to fund projects for preventing child abuse and neglect. A case management approach to meeting the needs of families on welfare is also being explored. The beginning of a comprehensive data base has been put together by a private non-profit agency. The Foundation for Seacoast Health in Portsmouth has funded a school site based child care and parenting program to allow teenage parents to finish school while learning about child development and parenting. The Children's Place in Concord was one of the first parent/child centers developed in the region. A child advocacy group is currently being formed.

Last Word: In my opinion there is now adequate evidence to indicate communities that establish a comprehensive, coordinated, non-deficit oriented community wide approach to promoting the health and development of families with young children can expect to see a significant reduction in low birth weight births, child abuse and neglect, hospitalizations of children under one for respiratory and gastrointestinal illnesses, and injuries, and an increase in the social and academic competence of children entering the school system. There will, in addition, be less feelings of isolation, loneliness, and depression in mothers of young children and a reduction in time lost from work by harried mothers with child care problems. Finally, there will be a greater sense of community cohesiveness and support by community residents. We have enough workable examples from this country and abroad to know how to go about doing this, and we know it will take a number of years to show the full effects. What we need to do is get started NOW!

Robert W. Chamberlin, M.D., M.P.H.

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Epilogue: Developing an Overall Framework

There were two follow up meetings after the November conference. During these we continued to work on developing an overall framework to use in promoting healthy families and children following the design of the Stanford three stage model. Persons in attendance at one or both meetings were: From Maine: John Serrage, MCH Director, Jane Weil, AIMS Project, Human Service Development Institute, University of Southern Maine, Charlene Rydell, legislator, and Steve Bauer, pediatrician from Norway, Maine; From New Hampshire: Charles Albano, MCH Bureau Chief, Mary Jane Wallner, legislator and day care provider, Marc Hiller from the Department of Health Management, and Policy, University of New Hampshire, Sue Bunting, Director, Foundation for Seacoast Health in Portsmouth, George Little, Chairperson, Department of Maternal Child Health of the Dartmouth Hitchcock Medical Center and Steve Kairys, a pediatrician and faculty member from the same department, and myself; From Vermont: Cheryl Mitchell, Director, Addison County Parent/Child Center, Francis Deflorio, District Manager, Department of Health, Brenda Bean, Planner for State Agency for Human Services.

The overall model developed by this group is presented on the diagram on the next page. A more detailed summary of status indicators, individual, and environmental factors follows this.

Program status indicators are those things to be assessed to ascertain the needs of families and children in the community and the ability of the community to meet those needs. Both can be monitored over time to assess program success.

Individual factors are the knowledge, attitudes, behaviors, and skills that individuals in the community need to possess in order to move the status indicators in a positive direction.

Environmental factors are the family, peer, organizational, mass media, and local and state government pressures that impact the knowledge, attitudes, behaviors, and skills of individuals in a positive or negative direction.

I. SUMMARY OF PROGRAM STATUS INDICATORS

1. Status of Families in a Defined Geographic Area:

A. Economic Status:

1. per capita or median income
2. % unemployment

Overall Framework for Promoting Healthy Families and Children

ENVIRONMENTAL FACTORS ➡	INDIVIDUAL FACTORS THAT INFLUENCE STATUS INDICATORS ➡	STATUS INDICATORS
Family and Peer Group: - stability - attitudes and values - instrumental and emotional support - ethnic culture and traditions	Knowledge: - fetal and child development, reproductive anatomy and physiology, health habits effecting pregnancy outcome, hazards of drugs, alcohol, sexually transmitted disease	Status of Families: - economic - stress load - coping capacity
Organizational Policies and Practices: - health care providers - schools - child care providers - churches - businesses - health and human service agencies	Feelings, Attitudes and Beliefs: - self-confidence, self-esteem, locus of control, career aspiration, prevention is important	Status of Women - educational level - maternal mortality - health habits related to outcome of pregnancy - reproductive history
Community: mass media: - attention, education and creating service demand local level: - orientation, rules and regulation affecting access, coordination, comprehensiveness, advocacy, promotion of cohesiveness, funding levels, database state level: - database, rules and regulations affecting access, interagency collaboration, standards, technical assistance, funding levels, equalization of resources	Behaviors and Skills: - basic living - job and school competence - household mnanagement - birthing - parenting - other	Status of Children and Youth - health and safety - growth and nutrition - behavior and development
	Demographic and Others - age - sex - education level - ethnic background - social class - personality and/or temperament	Status of Community - cohesiveness - access to education and support services

3. # and % of families below 100%, 150%, and 200% of the federal poverty level.
4. # and % of children in this stage of development below same levels.
5. # and % of families without adequate health insurance.
6. median rent for two bedroom apartment including heat and electricity.
7. # and % of families paying more than 40% of their take home pay for housing.
8. # and % of families without adequate housing.
9. # and % of families without a phone.
10. # and % of families without reliable transportation.

B. *Stress Load* for Individual Families and Mean Stress Score and Distribution Pattern for the Community. (See Risk Factor Check List on next page)

C. *Coping Capacity of Families in this Area:*
  1. Rates of Family Violence:
     a) spouse abuse
     b) child abuse (physical)
     c) child neglect (physical)
  2. Rates for Substance Abuse:
     a) alcohol
     b) drugs
  3. Separation and/or Divorce Rates
  4. Rates for Suicide and Homicide
  5. Hospitalization Rates for Mental Illness
  6. Feelings of Isolation, Loneliness, and Depression
  7. Feelings of Self Confidence, Self Esteem, and Optimism

RISK FACTOR CHECKLIST

(1B.) Family Stress Load:

1. *Income Related*
______ less than high school education
______ lack of job skills
______ job instability, 2 or more job changes past year
______ low paying job
______ paying 50% or more of income for housing
______ poor quality housing
______ no or inadequate health insurance
______ owe $2,000 or more for health care or educational expenses

2. *Isolated Living Situation*
______ a) move within last 6 months to new community, or two or more moves past year
______ b) living away from MGM, other family, friends
______ c) see family less than 1 time a month
______ d) rural area: geographical isolation
______ e) urban area, unsafe neighborhood, or discriminated against
______ f) no phone
______ g) mother doesn't have access to car or doesn't drive
______ h) lack of public transportation/no car
______ i) single parent living alone with children
______ j) lack of opportunity for peer support
______ k) foreign immigrant, lack of English
______ l) workaholic spouse
______ m) does not participate in community activities, church, etc.

3. *Other Stressful Living Situations*
______ a) household member has problem with substance abuse
______ b) family violence
______ c) disturbed marital relationship
______ d) chronic health problems in family members
______ e) chronic emotional problems in family members
______ f) 3 or more children under 5, or caring for difficult child
______ g) relationship problem with child
______ h) trouble with law
______ i) mother works full time and has trouble finding adequate child care program, and/or inflexible work schedule.
______ j) mother has little time or energy left for promoting development

4. *Lack of Knowledge About Child Development and/or Experience in Child Care*
______ a) immature adolescent
______ b) relies mostly on spanking and yelling for control
______ c) no prior experience in child care at home or at school

5. *Lack of Community Cohesiveness and Support*
______ a) no defined neighborhood or community center
______ b) no community wide programs to promote cohesiveness: drop-in centers, fairs, spaghetti dinners, etc.
______ c) high number of migratory residents, with short duration of stay
______ d) ideology of self sufficiency and non involvement
______ e) lack of after school/youth programs, child care, and preschool programs.

______ f) high rates of school drop out and delinquency, substance abuse

2. Status of Women in the Reproductive Age Period (15 to 45):

A. % high school education or more for those 20 years of age and older

B. Under age 20 and currently out of school because of pregnancy and/or child care responsibilities.

C. Maternal mortality rate

D. Health habits related to pregnancy outcome

E. Past history of pre-term labor, stillbirth, low birth weight baby, 2 or more miscarriages.

3. Status of Infants, Children, and Youths in Area by Stage of Development:

A. *Pregnancy/Neonatal*

1. Mother's Status at 1st Prenatal Visit:
   a) past history of preterm labor, stillbirth, low birth weight baby, 2 or more miscarriage.
   b) age
   c) marital status
   d) health habits related to pregnancy outcome:
      1. pre-pregnant weight
      2. use of cigarettes, alcohol, drugs
      3. birth interval
      4. month of entry into prenatal care
      5. occupation and physical activity
2. Mother's Status at Birth of Child and during Neonatal Period:
   a) bleeding during 2nd or 3rd trimester
   b) toxemia
   c) preterm delivery
   d) number of prenatal visits
   e) weight gain during pregnancy
   f) exposure of fetus to toxic substances
   g) amount of physical exertion during pregnancy
   h) maternal death related to child birth
3. Status of Infant at Birth/Neonatal Period:
   a) pregnancy terminated through spontaneous abortion
   b) pregnancy terminated through induced abortion
   c) stillbirth
   d) perinatal mortality rate
   e) neonatal mortality rate
   f) % received care in NICU

B. *Ages One Month to One year:*
  1. Health and Safety:
    a) post neonatal mortality rate
    b) infant mortality rate
    c) rehospitalization rate for NICU graduates
    d) rates for being hospitalized for gastrointestinal and/or respiratory disease.
    e) rates for hospitalization of suspected abuse and/or neglect
    f) hospitalizations for motor vehicle injury
    g) rate for total nonsurgical admissions
    h) % completion of primary immunization series by age one.
  2. Growth and Nutrition:
    a) concern about weight gain over 2 or more month period
    b) below 5% for height at age one
    c) below 5% for weight at age one
    d) below 5% weight for height at age one
    e) diagnosis of iron deficiency anemia during first year
  3. Developmental Status:
    a) considered developmentally delayed at age one
    b) exposure to abuse or neglect
      1. rates for foster care placement
    c) exposure to lead: % with significant blood levels

C. *Ages 1 Through 4:*
  1. Health and Safety:
    a) mortality rate
    b) hospitalization rate: nonsurgical
    c) mortality rate for injuries all kinds
    d) hospitalization rate: injuries and ingestions
    e) not fully immunized at entry into Head Start or other public preschool program at age 3 or 4.
    f) killed or hospitalized because of child abuse injuries
  2. Growth and Nutrition:
    a) below 5% height for age
    b) below 5% weight for age
    c) below 5% weight for height
    d) 95% or above weight for age
    e) above 95% weight for height
    f) diagnosis of iron deficiency anemia
    g) in need of dental care at entry into Head Start or other preschool program at 3 or 4.
  3. Development and Behavior:
    a) in need of speech therapy at age 3 (entry into Head Start or EPDST).

- b) exposure to abuse or neglect
  - 1. rates for placement in:
    - a) in foster care
    - b) subsidized day care
- c) exposure to lead; abnormal blood test
- d) failed Denver Developmental Test at age 1, 2, 3, or 4

D. *Ages 5 Through 12:*

- 1. Health and Safety:
  - a) rates for hospitalization
  - b) % children with chronic illness requiring regular treatment and/or medical supervision.
  - c) fully immunized at kindergarten entry
- 2. Growth and Nutrition:
  - a) below 5% height for age
  - b) below 5% weight for age
  - c) above 95% weight for height
  - d) untreated dental caries noted at school entry
  - e) DMF rate: at school entry
- 3. Development and Behavior:
  - a) exposure to abuse and neglect
    - 1. in foster care or family being monitored for physical abuse
    - 2. in foster care or family being monitored for sexual abuse
    - 3. in foster care or family being monitored for neglect
  - b) rate of CHINS Hearings
  - c) rate of delinquency
  - d) rates for substance abuse, suicide, homicide
  - e) requiring special education services: any reason
  - f) requiring Chapter I services: any reason
  - g) repeated a grade

E. *Ages 13 Through 19:*

- 1. Health and Safety:
  - a) motor vehicle injury rate
  - b) STD rate
  - c) induced abortion rate
- 2. Growth and Nutrition:
  - a) weight for height > 95%
  - b) weight > 95%
  - c) height < 5%
  - d) weight < 5%
- 3. Behavior and Development:
  - a) out of wedlock pregnancy rate
  - b) rates for use and abuse of: alcohol, drugs, cigarettes

- c) delinquency rate
- d) CHINS rate
- e) homicide rate
- f) suicide rate
- g) school drop-out rate
- h) exposure to abuse and/or neglect
  1. rates for foster care, group home placement
  2. rates for home situation being actively monitored
- i) rates for being a teenage parent and not having finished high school and not being in school now.

4. Status of Community:

A. *Cohesiveness:*

1. residents feel sense of community
2. frequent contact with neighbors and other community residents, tradition of neighbor helping neighbor.
3. high degree of participation in community events
4. deliberate effort to sponsor community events that promote cohesiveness.
5. availability of multipurpose community center for activities and meetings.
6. Geographically identifiable community center for shopping and activities (as opposed to suburban sprawl).
7. in and out migration less than 10% a year
8. low rate of vandalism

B. *Access to Education and Support Services:*

1. information and referral service
2. accessible and affordable quality preschool programs for 3 and 4 year olds.
3. public kindergarten for 5 year olds
4. special education services for those with special needs and public buildings accessible to the handicapped, developmental screening and referral.
5. affordable development promoting day care and after school programs for children of working mothers.
6. recreation and skill building activities for youths and adolescents of both sexes.
7. respite services for families with difficult children
8. opportunities for parent education and peer support for parents: drop-in center, toddler play groups, support groups for persons undergoing difficult life situations.
9. home visiting program to reach families with special needs
10. transportation system to help people from isolated rural area access services.

II. SUMMARY OF INDIVIDUAL FACTORS

1. **Parents, Youths, and Adolescents:**
   - A. Knowledge: Fetal, child, and adolescent development, reproductive anatomy and physiology, health habits affecting pregnancy outcome, why don't want to have a low-birth weight baby, child spacing, sexually transmitted disease, hazard of drugs and alcohol, nutrition, community resources, preventive programs work.
   - B. Feelings, Attitudes, and Beliefs: Self confidence, self esteem, locus of control, prevention is important, nobody is entirely self sufficient, career aspirations.
   - C. Behaviors and Skills, Coping Capacity:
     1. Basic living: communication, problem solving, stress reduction, assertiveness, conflict resolution, resisting peer pressure, independence in self care.
     2. Job and/or school competence
     3. Household management: maintaining order and routine with flexibility, budgeting, shopping, maintenance and repair.
     4. Birthing:
        - a) health habits related to pregnancy outcome
        - b) preparation for labor and delivery
        - c) breast feeding and infant care
        - d) child spacing
     5. Parenting:
        - a) Promotion of health and safety: basic sanitation and hygiene, prevention and care of common illnesses, safe home environment, use of seat belts, how to access health care system, use of preventive care, dental care, and nutrition.
        - b) Promotion of speech, language, and cognitive development: labelling, reading to, encouraging verbalizations, exposure to a variety of experiences, playing learning games with.
        - c) Promotion of social competence and positive self esteem: provides praise, positive feedback, encouragement, hugs, spends time with, encourages participation in social situations and peer groups.
        - d) Promotion of independence and self care: encourages child to feed and dress self, manage toileting and personal hygiene, separation from mother.
        - e) Behavioral management: can use alternatives to spanking, yelling, threats, and shaming (time out, distraction, ignoring, positive reinforcement).

- f) Basic infant and child care: feeding and nutrition, bathing, etc.
6. Other skills: driving, balance between work and family needs, participation in community events.

2. Demographic and Other: (see diagram)

III. SUMMARY: ENVIRONMENTAL FACTORS

1. Family and Peers:

A. *Family:*
  1. Stability and safety of living situation
  2. Attitudes and values about: sexuality, use of drugs, cigarettes and alcohol, birth control, violence, sex roles, role of government, religion.
  3. instrumental and emotional support from spouse, maternal grandmother, other relatives.
  4. ethnic traditions

B. *Peers:*
  1. Attitudes and values as above
  2. instrumental and emotional support

2. Organizations and Providers:

A. *Health Care Providers:* Capacity for outreach; access to preventive and sick care; comprehensive approach to screening, evaluation, and treatment; education and support; coordination between prenatal and child care programs; linkage with tertiary care; advocacy for children and families.

Hospitals: Birthing room, promotion of early contact and bonding, support of breast feeding, education and support for hospitalized children.

B. *Business:* Health insurance, flexible work schedules including part-time work with benefits, paid pregnancy and child care leave, information and referral, subsidized child care and parenting programs.

C. *Schools:* Curriculum: reproductive anatomy and physiology, fetal development, how mothers health habits affect pregnancy outcome, birth control, boy-girl relationships, how your body works, opportunities for experience in child care, what parents can do to promote child development: health and safety, growth and nutrition, behavioral management, cognitive, speech and language, and social/emotional. Peer Counseling, On Site Child Care and Parenting Programs, On Site Health Care and Career Counseling, Mental Health Promoting Atmosphere, Early Intervention and Preschool Programs, Developmental Screening, Special Education.

D. *Churches:* Youth programs, human sexuality, child care programs, parent/child centers, support groups.

E. *Child Care Providers:* Access, family education and support, flexible hours, illness care, knowledge about child development, behavior management, skills in promoting development, health and safety, nutrition.

F. *Human Service Agencies:* Orientation, access, comprehensiveness, standards.

3. Community:

A. *Mass Media:* Education about child and adolescent development, parenting, what's happening to families and children in the area, model programs, gaps in services, section for teens on STD, drugs and alcohol, sexuality, birth control, need for overall family policy, prevention works.

B. *Local Level:* Overall policy, data base, interagency collaboration in program development and funding, I & R service, youth programs, subsidized child care and preschool programs, affordable housing, prenatal and child health care programs, educational and job training opportunities, public transportation, advocacy for state legislation, non-deficit orientation to service delivery, developmental screening, recreation programs, open space, respite care, exposure to environmental toxins.

C. *State Level:*

1. *Executive Branch and State Agencies:* Overall policy on families and children, interagency collaboration, eligibility and reimbursement rates for medicaid and day care, standards for child care, capacity for technical assistance, start up money, school curriculum guideline, provider training programs, data base to monitor child and family status, opportunities for higher education, income and job protection, economic development.
2. *Legislative Branch:* Overall policy to guide direction, state funding for family support and child education and care programs, mandates for interagency collaboration, caucus to advocate for child and family programs, housing, health

insurance, economic development and job security, equalization of resources for program development, funding for child care and early education programs.

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